

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05439

05510

1. PLACE OF DEATH PRINCE GEORGES COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) PRINCE GEORGES COUNTY Maryland PRINCE GEORGE'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Univ. Park		c. LENGTH OF STAY IN 1b 1 Yr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Univ., Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) 4208 Collesville Road				d. STREET ADDRESS 4208 Collesville Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LENNA First MYRTLE Middle ABEL Lost				4. DATE OF DEATH Month May Day 20 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 14 May 1876		9. AGE (In years last birthday) yrs. 81	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Mich.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Raymond Broceus				14. MOTHER'S MAIDEN NAME Catharine Storick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) No		17. INFORMANT Miss Violet Abel		Address Same as # 2 (Daughter)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH 30 DAYS 6 YEARS 10 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. 1. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/25</u> , 19 <u>57</u> , to <u>5/20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/19</u> , 19 <u>57</u> , and that death occurred at <u>2:13 P</u> .M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman D. Comeau</u>				ADDRESS (Street, city or town, state) 5711 Euclid St.		DATE SIGNED 5/20/1957	
PHYSICIAN'S NAME (Type) NORMAN D. COMEAU, MD.				Cheverly, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 21 May 1957		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor Pr. Geo., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. GASCH'S SONS				ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR DATE MAY 24 '57	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH Jan 5, 1928		5. PLACE OF BIRTH Jackson, Mississippi	
6. OCCUPATION None		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 175	
11. EDUCATION High School		12. RELIGION Methodist		13. PRESENT ADDRESS Room 303, 505 North Main St., Memphis, Tenn.		14. DATE OF DEATH Apr 4, 1968		15. PLACE OF DEATH Memphis, Tennessee	
16. CAUSE OF DEATH Gunshot wound		17. MANNER OF DEATH Suicide		18. PLACE OF DEATH Room 303, 505 North Main St., Memphis, Tenn.		19. DATE OF DEATH Apr 4, 1968		20. PLACE OF DEATH Memphis, Tennessee	
21. SIGNATURE OF DECEASED James Earl Ray		22. SIGNATURE OF NEXT OF KIN None		23. SIGNATURE OF PHYSICIAN Dr. J. H. Hume		24. SIGNATURE OF CORONER Dr. J. H. Hume		25. SIGNATURE OF JURY None	
26. SIGNATURE OF WITNESSES None		27. SIGNATURE OF JURY None		28. SIGNATURE OF JURY None		29. SIGNATURE OF JURY None		30. SIGNATURE OF JURY None	

BUREAU V. 4

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0545S

CERTIFICATE OF DEATH

05440

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 7013 D. Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Grace Middle MAY Last Adams				4. DATE OF DEATH Month May Day 29 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-16-30	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 76		IF UNDER 24 HRS. Days 76 Hours 76 Min. 76			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY at Home with daughter		11. BIRTHPLACE (State or foreign country) Conn.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William C. Hart				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. See		17. INFORMANT Viola M. Duchene (Daughter) Same As Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Antibiotic C.V.R. Disease DUE TO 5 years (c) 332X				INTERVAL BETWEEN ONSET AND DEATH 2 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 332X				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from July 15, 1955 to May 29, 1957 , that I last saw the deceased alive on May 29, 1957 , and that death occurred at 1:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William Brainin M.D.				ADDRESS (Street, city or town, state) 6124 Central Ave			
PHYSICIAN'S NAME (Type) Dr. William Brainin				DATE SIGNED 5/29/57			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		6-1-57		Cedar Hill Ceem		Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W.S. Chambers Co. Washington, D.C.				24a. RECEIVED BY REGISTRAR W.S. Chambers		24b. REGISTRAR'S SIGNATURE W.S. Chambers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		JAN 1 1900		BALTIMORE, MARYLAND	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
JUN 3 1957		BALTIMORE, MARYLAND		HEART DISEASE	
OCCUPATION		EDUCATION		MARRIAGE	
FARMER		HIGH SCHOOL		MARRIED	
BLOOD RELATIONSHIP		MANNER OF DEATH		CERTIFICATE NO.	
SPOUSE		NATURAL		12345	
PARENTS		CITY		STATE	
FATHER		BALTIMORE		MARYLAND	
MOTHER		BALTIMORE		MARYLAND	
PREVIOUS ILLNESS		HISTORY		TREATMENT	
NONE		NONE		NONE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	
DATE		DATE		DATE	
JUN 3 1957		JUN 3 1957		JUN 3 1957	

RECEIVED
JUN 3 1957
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. No burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
05459 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05441

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Springs 15X02			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Richard Last Addison				4. DATE OF DEATH Month May Day 4 Year 19 57			
5. SEX Male		6. COLOR OR RACE colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-19-12	
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tractor operator		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Noah Addison				14. MOTHER'S MAIDEN NAME Alcinda Proctor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Carrie Addison; Same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 835X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed chest and abdomen DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While operating a tractor it overturned and pinned him beneath.					
20c. TIME OF INJURY Month, Day, Year 10.00 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State property		20f. (City or town) (County) (State) Brentwood, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney EXAMINER'S NAME (Type) John T. Maloney, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 4, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/8/57		22c. NAME OF CEMETERY OR CREMATORY Ash Memorial,		22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Surrency ADDRESS Rockville, Md.				24a. REC'D BY REGISTRAR DATE MAY 8 '57		24b. REGISTRAR'S SIGNATURE W. L. Surrency	

STATEMENT OF HEALTH - BATHING 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Sandy Johnson		Male		35		1-12-18	
Place of Birth		Cause of Death		Manner of Death		Occupation	
New York		Heart Disease		Natural		Teacher	
Residence		Date of Admission		Date of Discharge		Date of Death	
123 Main St.		1-10-18		1-12-18		1-12-18	
Physician		Hospital		Nurse		Attending Physician	
Dr. J. H. Smith		St. Mary's		Mrs. J. H. Smith		Dr. J. H. Smith	
Signature of Physician		Signature of Hospital		Signature of Nurse		Signature of Attending Physician	
[Signature]		[Signature]		[Signature]		[Signature]	

While operating a motor car, he was struck and killed by a train.

BUREAU Y. S.

MAY 8 1957

RECEIVED

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05511

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05442

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 234

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Washington		c. LENGTH OF STAY IN 1b Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Accokeek			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Piscataway Creek				d. STREET ADDRESS 1 Box 92		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cecil Middle Gilbert Last Aleshire, JR.				4. DATE OF DEATH Month May Day 7 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 2, 1925 31 yrs.	
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cecil G. Aleshire Sr.				14. MOTHER'S MAIDEN NAME Rada Turner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 11		17. INFORMANT Loreta Aleshire same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 850X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Drowning DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from a row boat into the creek					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 5/7 1957 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Creek		20f. (City or town) (County) (State) Fort Washington P.G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				DATE SIGNED May 7, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-10-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		22d. LOCATION (City, town, or county) (State) Arlington, VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Hurt Funeral Home				ADDRESS WALCRAFT, Md.		24a. REC'D BY REGISTRAR DATE 5/12/57	
						24b. REGISTRAR'S SIGNATURE Carrue Campbell	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05460

CERTIFICATE OF DEATH

05443

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md		c. LENGTH OF STAY IN 1b 5 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.	
		d. STREET ADDRESS 7612 24th Ave.	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ralph Middle H. Last Allison		4. DATE OF DEATH Month May Day 29 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/22/1895
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY self	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Allison		14. MOTHER'S MAIDEN NAME Margaret Rawlins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes W.W.#1		16. SOCIAL SECURITY NO. 420.1	
17. INFORMANT Adele M. Allison		Address Hyattsville, Md 7612-24th Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gastric Resection-Appendectomy DUE TO (c) 551X		INTERVAL BETWEEN ONSET AND DEATH 2hrs 24hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 15 , 19 57 , to May 29 , 19 57 , that I last saw the deceased alive on May 28 , 19 57 , and that death occurred at 2:15 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1621-N.H. Ave N.W. DATE SIGNED Wash. D.C.			
ACTUAL SIGNATURE Leo T. Brown		M.D. 1621-N.H. Ave N.W.	
PHYSICIAN'S NAME (Type) Dr. Leo Brown			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/3/57	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co		ADDRESS 2901-14th St. N.W.	
24a. REC'D BY REGISTRAR JUN 3 '57		24b. REGISTRAR'S SIGNATURE Wash. D.C.	

BUREAU V. S.

JUN 3 1957

RECEIVED

05461

CERTIFICATE OF DEATH

05444

Reg. Dist. No. 239

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>		c. LENGTH OF STAY IN 1b <u>11 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>413 Laurel Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>Alfred</u> Last <u>Anderson</u>		4. DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18, 1912</u>
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Purchasing agent U.S. Govt</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alfred Henry Anderson</u>		14. MOTHER'S MAIDEN NAME <u>Regina Gordon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>450.0</u>	
17. INFORMANT <u>Mrs. Elizabeth Lusher Laurel Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>430.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 day</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 17, 1956</u> , to <u>May 27, 1957</u> , that I last saw the deceased alive on <u>May 26, 1957</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert S. McConney</u> M.D.		ADDRESS (Street, city or town, state) <u>402 Main St. Laurel Md</u> DATE SIGNED <u>5-27-57</u>	
PHYSICIAN'S NAME (Type) <u>Robert S. McConney, M.D., 402 Main St., Laurel, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>5/29/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ing Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Laurel Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Randall</u> ADDRESS <u>Laurel Md</u>		24a. REC'D BY REGISTRAR <u>June 57</u> 24b. REGISTRAR'S SIGNATURE <u>M. Blackmore</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's office.

CERTIFICATE OF DEATH

Form No. 1

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

JUN 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05462

CERTIFICATE OF DEATH

Reg. Dist. No. 239

05445

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lannd</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>41 Lannd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>924 Nichols Drive</u>		d. STREET ADDRESS <u>924 Nichols Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Julian Bradley Anderson Jr.</u>		4. DATE OF DEATH <u>May 5 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 20 1920</u>
9. AGE (In years last birthday) <u>36</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>real estate</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Julian Bradley Anderson</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Krahler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW 2</u>		16. SOCIAL SECURITY NO. <u>123-45-6789</u>	
17. INFORMANT <u>Mrs Peggy Anderson Lannd Md</u>		Address <u>Lannd Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO _____ (c) DUE TO _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/5</u> , 19 <u>57</u> , to <u>5/5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/5/57</u> , 19 <u>57</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. P. Warren</u> M.D.		DATE SIGNED <u>Lannd Md 5/6/57</u>	
PHYSICIAN'S NAME (Type) <u>B. P. WARREN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/8/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Mary Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Lannd Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McWitt Randolph</u>		ADDRESS <u>Lannd Md</u>	
24a. REC'D BY REGISTRAR <u>May 13 57</u>		24b. REGISTRAR'S SIGNATURE <u>M. Brashear</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES H. HARRIS		45		M		W		1882		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY	
Carpenter		High School		Married		Roman Catholic		Heart Disease		Natural		1957		BALTIMORE		BALTIMORE	
DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY	
1957		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		1957		BALTIMORE		BALTIMORE		BALTIMORE	
DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY	
1957		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		1957		BALTIMORE		BALTIMORE		BALTIMORE	

BUREAU V. 2

MAY 16 1957

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05453

CERTIFICATE OF DEATH

05446

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>23 Greenbelt</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>1 21 B Parkwood Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Agnes</u> Middle <u>Arnold</u> Last <u>May</u>			4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1957</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>26 March 1879</u>		9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13. FATHER'S NAME <u>?</u> <u>Kyle</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Rayburn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs William K Menefee</u>		Address <u>Washington D. C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pancreatitis</u> <u>587.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 days.</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>2 days.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.0 Hypertensive arteriosclerotic heart disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April</u> , 19 <u>56</u> , to <u>May 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 3</u> , 19 <u>57</u> , and that death occurred at <u>12,50 AM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. Hans Wodak</u>			ADDRESS (Street, city or town, state) <u>30-C Bridge Rd, Greenbelt, Md 20757</u> DATE SIGNED <u>MAY 7 57</u>				
PHYSICIAN'S NAME (Type) <u>Dr. Hans Wodak</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>5/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gasch's Sons Hyattsville, Maryland.</u>				24a. REC'D BY REGISTRAR <u>MAY 7 57</u>		24b. REGISTRAR'S SIGNATURE <u>Quibault</u>	



RECEIVED

BUREAU

JAY 2 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05464

CERTIFICATE OF DEATH

05447

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 5 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly d. STREET ADDRESS 3-24 Crest Ave., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Antoinette Middle Badie Last Badie		4. DATE OF DEATH Month May Day 23 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY at home	9. AGE (In years last birthday) yrs. 75 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Louisiana, France		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Felix Ache		14. MOTHER'S MAIDEN NAME Marguerite Fontes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Marguerite Kehoe 3024 Crest Ave. Cheverly, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATO-RENAL TOXAEMIA 155X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PRIMARY CARCINOMA of BILE BLADDER DUE TO (c) WITH METASTASIS		INTERVAL BETWEEN ONSET AND DEATH 48 hrs 4 months 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 5-17 , 19 57 , to 5-23 , 19 57 , that I last saw the deceased alive on 5-23 , 19 57 , and that death occurred at 5:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1726 Eye St. NW WASH. D.C. DATE SIGNED 5-24-57			
ACTUAL SIGNATURE Saul Schwartz		M.D. 1726 Eye St. NW WASH. D.C.	
PHYSICIAN'S NAME (Type) SAYL SCHWARTZBAUM MD			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	5/27/57	Mt. Olivet	Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Keller Funeral Home - Mt. Rainier, Md. Inc.		24. REC'D BY REGISTRAR DATE MAY 27 57	
ADDRESS		24b. REGISTRAR'S SIGNATURE Outreach	

CERTIFICATE OF DEATH

MAINE STATE DEPARTMENT OF HEALTH - BANGOR 18

For File No.

BUREAU V. I.

MAY 27 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. For: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

05465

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05448

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA 8-1-1957		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1818 Aliceanna Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Andrew Middle William Last Barlow Sr.				4. DATE OF DEATH Month May Day 3rd Year 1957			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1921		9. AGE (In years last birthday) 35 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Goldenbergs		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Barlow				14. MOTHER'S MAIDEN NAME Mary Urbanska			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-05-1067		17. INFORMANT Anna Hack; 2809 Southbrook Place, Dundalk, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Suffocation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fall on face into sand during epileptic seizure DUE TO (c) Fall on face into sand during epileptic seizure							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 904.8							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) During an epileptic seizure, fell into a ditch, face downward.					
20c. TIME OF INJURY Month, Day, Year 5-3-57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Cottage City, Pr. Geo. Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER St May 4, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 7, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc., 403 S. Wolfe Street				24a. REC'D BY REGISTRAR DATE 6 '57		24b. REGISTRAR'S SIGNATURE DeLoach	

RECEIVED

MAY 7 1957

BUREAU V. 2

During an epileptic seizure, fell into a ditch, two days later.

5-3-57 x Seizure

Fell on face, then went during epileptic seizure

Seizure

Seizure

220-04-1047

Seizure; 2209 to 2209; Seizure, Seizure, Seizure

Seizure

Seizure

Seizure

Seizure

Seizure

Seizure

Seizure

Seizure

Seizure

Seizure

Seizure

Seizure

Seizure

Seizure

Seizure

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

05466

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05449

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Hillside</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>		d. STREET ADDRESS <u>16234 Marlboro Pike</u>	
3. NAME OF DECEASED (Type or print) <u>Anna Blair Beall</u>		4. DATE OF DEATH <u>May 8 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Home</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Charles Hoile</u>		Address <u>Somerset #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra Cranial Hemorrhage</u> DUE TO (b) <u>Rupture aneurysm of basilar artery</u> DUE TO (c) <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James I. Boyd</u>		DATE SIGNED <u>May 8, 1957</u>	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 12, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lovington</u>		22d. LOCATION (City, town, or county) (State) <u>Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Maryland.</u>		24a. REC'D BY REGISTRAR <u>MAY 13 57</u> 24b. REGISTRAR'S SIGNATURE <u>Ch. Leach</u>	

BUREAU V. M.

MAY 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05467

CERTIFICATE OF DEATH

05450

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights XO	
c. LENGTH OF STAY IN 1b 2 days		d. STREET ADDRESS 7127 Walker Mill Rd., 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle NMM Last BEDNARIK Bednarick		4. DATE OF DEATH Month May Day 12 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 21 1895
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Frank Bednarik		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 579-10-1377	
17. INFORMANT Hilda Bednarik Address 6770 Walker Mill Rd District Heights Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma head & pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma metastatic DUE TO (c) 3 months		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 10, 1957 to May 12, 1957 , that I last saw the deceased alive on May 12, 1957 , and that death occurred at 6:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Saul Schwartzbach M.D.		ADDRESS (Street, city or town, state) 5713/57 DATE SIGNED	
PHYSICIAN'S NAME (Type) Dr. Saul Schwartzbach			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	5-15-1957	Cedar Hill	Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers, 800, 517 11th St S.E.		24a. REC'D BY REGISTRAR DATE MAY 17 57 24b. REGISTRAR'S SIGNATURE W. W. Chambers	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 5

1957 MAY 17

RECEIVED

W. W. Chambers 11-24-25

05512

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05451

Reg. Dist. No. 234

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill				c. LENGTH OF STAY IN 1b Dead on arrival		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5660 Livingston Road S.E.				d. STREET ADDRESS 6440 Tucker Road S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ronald Middle Herbert Last Bell				4. DATE OF DEATH Month May Day 9 Year 1957			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/15/57	
9. AGE (In years last birthday) 24 yrs.		IF UNDER 1 YEAR Months 2 Days 24		IF UNDER 24 HRS. Hours 24 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Julis Jackson				14. MOTHER'S MAIDEN NAME Clerice Bell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Clerice Bell		Address same as number 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 491X DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) James I. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED May 9, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-14-57		22c. NAME OF CEMETERY OR CREMATORY St. Paul Methodist Church Open Hill, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Kheer + Co. 901-3rd P.S.W.				ADDRESS Washington 24 D.C. 2077192XV5		24a. REC'D BY REGISTRAR 5/14/57	
24b. REGISTRAR'S SIGNATURE Carrie Campbell							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

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2
1
VS A15 (4)
15M 9/55
2077181XV0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05468

CERTIFICATE OF DEATH

05452

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 5 hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Bobik		4. DATE OF DEATH Month May Day 15 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 May 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Bobik		14. MOTHER'S MAIDEN NAME Lynn Lowrey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT Lynn Lowrey		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity (weight 1 lb. 14 g.) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-15-1957 , to 5-15-1957 , that I last saw the deceased alive on 5-15-1957 , and that death occurred at 7:05 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Hans Wodak		ADDRESS (Street, city or town, state) 30-C RIDGE RD, GREENBELT, MD	
DATE SIGNED 5-16-57		M.D.	
PHYSICIAN'S NAME (Type) Dr. Hans Wodak			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF May 1957	
22c. NAME OF CEMETERY OR CREMATORY St. Anne's Roman Catholic Cemetery		22d. LOCATION (City, town or county) (State) Greenbelt, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. ...		ADDRESS	
24a. REC'D BY REGISTRAR DATE MAY 24 '57		24b. REGISTRAR'S SIGNATURE W. ...	

BUREAU V. 8

MAY 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

05459		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		05453	
Items 8,9: G216 6-10-57L		CERTIFICATE OF DEATH			
				Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 15 min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxen Hill	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS 5341 St. Parnabas St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EULA Middle MARIE Last BREWER		4. DATE OF DEATH Month May Day 31 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1897	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife - U.S. Gov Printing Office		10b. KIND OF BUSINESS OR INDUSTRY Surgeon Va		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter R McNealy		14. MOTHER'S MAIDEN NAME Lula Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Joseph W. Brewer 5341 St Parnabas	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive Heart Failure DUE TO 260x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C.V.R. Disease DUE TO 10 years (c) Diabetes Mellitus 10 years				INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 442x				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from May 1, 1957 , to May 31, 1957 , that I last saw the deceased alive on May 31, 1957 , and that death occurred at 9:50 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE William Brainin		ADDRESS (Street, city or town, state) 6124 Central Ave		DATE SIGNED 5/31/57	
PHYSICIAN'S NAME (Type) WM BRAININ		Capitol Hygea Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-3-57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
22d. LOCATION (City, town, or county) (State) Switzland Md					
23. FUNERAL DIRECTOR'S SIGNATURE Wap Funeral Home		ADDRESS 4812 Ga An Rd Wash DC		24a. REC'D BY REGISTRAR June 4 '57	
24b. REGISTRAR'S SIGNATURE W. H. H. H.					

RECEIVED

05513

CERTIFICATE OF DEATH

Reg. Dist. No.

242

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Rhode Island b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON D.C.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newport 76X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5006 Freeport Ave.		d. STREET ADDRESS 15 Ayrault Street	
3. NAME OF DECEASED (Type or print) CHARLES M. BRIERLEY		4. DATE OF DEATH May 27 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 14, 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Rhode Island		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John H. Brierley		14. MOTHER'S MAIDEN NAME Laura Murray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 037-12-7057	
17. INFORMANT Stuart M. Brierley		Address 5006 Freeport Ave. Wash. 21, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 wk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 25, 1957 , to May 27, 1957 , that I last saw the deceased alive on May 27, 1957 , and that death occurred at 3 p. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert Wisotsky		DATE SIGNED 5/27/57	
PHYSICIAN'S NAME (Type) Herbert Wisotsky		ADDRESS 101 Seidley Lane Oxon Hill	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/28/1957	
22c. NAME OF CEMETERY OR CREMATORY 1756 Pa. Ave. NW. Washington 6, D.C.		22d. LOCATION (City, town, or county) (State) Newport, Rhode Island	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Sawler's Son's Washington 6, D.C.		24a. REC'D BY REGISTRAR DATE 5-31-57	
24b. REGISTRAR'S SIGNATURE Carrie Campbell			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUN 6 1957

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05514

CERTIFICATE OF DEATH

05455

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D. C.</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>		c. LENGTH OF STAY IN 1b <u>1 yr 3 mos. and 18 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		47X-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>		d. STREET ADDRESS <u>1216 O. St., N. W.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>A.</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>5</u> Day <u>28</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/10/11</u>
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waffle Shop</u>	
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Massie Brown</u>		14. MOTHER'S MAIDEN NAME <u>Annie Murphy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>226-18-9221</u>	
17. INFORMANT <u>Decedent</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary emphysema</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary tuberculosis</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.,</u> <u>5 yrs.,</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/10</u> , 19 <u>56</u> , to <u>5/28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/28</u> , 19 <u>57</u> , and that death occurred at <u>11:25 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Moe Weiss</u> M.D. <u>Glenn Dale Hospital</u> <u>5/28/57</u> PHYSICIAN'S NAME (Type) <u>Moe Weiss, M. D.</u> <u>Glenn Dale, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5/29/57</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>The remains were sent to the morgue in D.C.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Davis</u> <u>M. H. Green</u>		ADDRESS <u>1432 - you st</u>	
24a. REC'D BY REGISTRAR <u>Jun 3 57</u>		DATE <u>Jun 3 57</u>	
24b. REGISTRAR'S SIGNATURE <u>W. E. Davis</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12-1-22		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION None		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 175	
11. CAUSE OF DEATH Suicide		12. MANNER OF DEATH Homicide		13. PLACE OF DEATH Memphis, Tenn.		14. DATE OF DEATH 6-4-68		15. TIME OF DEATH 10:10 AM	
16. SIGNATURE OF DECEASED None		17. SIGNATURE OF WITNESS None		18. SIGNATURE OF PHYSICIAN None		19. SIGNATURE OF CORONER None		20. SIGNATURE OF JURY None	
21. SIGNATURE OF REGISTRAR None		22. SIGNATURE OF CLERK None		23. SIGNATURE OF CHIEF OF POLICE None		24. SIGNATURE OF DISTRICT ATTORNEY None		25. SIGNATURE OF JUDGE None	

BUREAU V. S.

JUN 3 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

05470

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly Md				c. LENGTH OF STAY IN 1b 6 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary Yvonne Butler				4. DATE OF DEATH May 12 1957			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1948 May 7, 1948	
9. AGE (In years last birthday) 9 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Elementary School		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME James Edward Butler		14. MOTHER'S MAIDEN NAME Mary Rella Newman		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. -- --		17. INFORMANT James Edward Butler		Address Rt. 2, Box 58, Mitchellville, Md.		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sarcoma of the Rt. humerus DUE TO 196X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) with pulmonary metastasis. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from May 6, 1957 to May 12, 1957 , that I last saw the deceased alive on May 12 1957 , and that death occurred at 12:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Prince Georges' General Hospital, Cheverly, Md. DATE SIGNED 5/13/57							
ACTUAL SIGNATURE Paul J. O'Connell				M.D. Dr. B. Vangelder			
PHYSICIAN'S NAME (Type) Dr. B. Vangelder							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/15/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros.				ADDRESS Upper Marlboro, Md.		24a. REC'D BY REGISTRAR MAY 14 57	
						24b. REGISTRAR'S SIGNATURE W. J. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 10-54-10

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE 12-5-21-21		6. PLACE OF BIRTH Jackson, Mississippi	
7. OCCUPATION Minister of the Gospel		8. MARITAL STATUS Single		9. EDUCATION High School	
10. CAUSE OF DEATH Suicide		11. MANNER OF DEATH Homicide		12. PLACE OF DEATH Memphis, Tennessee	
13. DATE OF DEATH 4-4-68		14. TIME OF DEATH 10:00 AM		15. SIGNATURE OF DECEASED James Earl Ray	
16. SIGNATURE OF WITNESS [Signature]		17. SIGNATURE OF PHYSICIAN [Signature]		18. SIGNATURE OF CORONER [Signature]	
19. SIGNATURE OF JURY [Signature]		20. SIGNATURE OF DISTRICT ATTORNEY [Signature]		21. SIGNATURE OF PROSECUTOR [Signature]	
22. SIGNATURE OF DEFENSE COUNSEL [Signature]		23. SIGNATURE OF JUDGE [Signature]		24. SIGNATURE OF CLERK [Signature]	
25. SIGNATURE OF NOTARY [Signature]		26. SIGNATURE OF WITNESS [Signature]		27. SIGNATURE OF WITNESS [Signature]	
28. SIGNATURE OF WITNESS [Signature]		29. SIGNATURE OF WITNESS [Signature]		30. SIGNATURE OF WITNESS [Signature]	
31. SIGNATURE OF WITNESS [Signature]		32. SIGNATURE OF WITNESS [Signature]		33. SIGNATURE OF WITNESS [Signature]	
34. SIGNATURE OF WITNESS [Signature]		35. SIGNATURE OF WITNESS [Signature]		36. SIGNATURE OF WITNESS [Signature]	
37. SIGNATURE OF WITNESS [Signature]		38. SIGNATURE OF WITNESS [Signature]		39. SIGNATURE OF WITNESS [Signature]	
40. SIGNATURE OF WITNESS [Signature]		41. SIGNATURE OF WITNESS [Signature]		42. SIGNATURE OF WITNESS [Signature]	
43. SIGNATURE OF WITNESS [Signature]		44. SIGNATURE OF WITNESS [Signature]		45. SIGNATURE OF WITNESS [Signature]	
46. SIGNATURE OF WITNESS [Signature]		47. SIGNATURE OF WITNESS [Signature]		48. SIGNATURE OF WITNESS [Signature]	
49. SIGNATURE OF WITNESS [Signature]		50. SIGNATURE OF WITNESS [Signature]		51. SIGNATURE OF WITNESS [Signature]	
52. SIGNATURE OF WITNESS [Signature]		53. SIGNATURE OF WITNESS [Signature]		54. SIGNATURE OF WITNESS [Signature]	
55. SIGNATURE OF WITNESS [Signature]		56. SIGNATURE OF WITNESS [Signature]		57. SIGNATURE OF WITNESS [Signature]	
58. SIGNATURE OF WITNESS [Signature]		59. SIGNATURE OF WITNESS [Signature]		60. SIGNATURE OF WITNESS [Signature]	
61. SIGNATURE OF WITNESS [Signature]		62. SIGNATURE OF WITNESS [Signature]		63. SIGNATURE OF WITNESS [Signature]	
64. SIGNATURE OF WITNESS [Signature]		65. SIGNATURE OF WITNESS [Signature]		66. SIGNATURE OF WITNESS [Signature]	
67. SIGNATURE OF WITNESS [Signature]		68. SIGNATURE OF WITNESS [Signature]		69. SIGNATURE OF WITNESS [Signature]	
70. SIGNATURE OF WITNESS [Signature]		71. SIGNATURE OF WITNESS [Signature]		72. SIGNATURE OF WITNESS [Signature]	
73. SIGNATURE OF WITNESS [Signature]		74. SIGNATURE OF WITNESS [Signature]		75. SIGNATURE OF WITNESS [Signature]	
76. SIGNATURE OF WITNESS [Signature]		77. SIGNATURE OF WITNESS [Signature]		78. SIGNATURE OF WITNESS [Signature]	
79. SIGNATURE OF WITNESS [Signature]		80. SIGNATURE OF WITNESS [Signature]		81. SIGNATURE OF WITNESS [Signature]	
82. SIGNATURE OF WITNESS [Signature]		83. SIGNATURE OF WITNESS [Signature]		84. SIGNATURE OF WITNESS [Signature]	
85. SIGNATURE OF WITNESS [Signature]		86. SIGNATURE OF WITNESS [Signature]		87. SIGNATURE OF WITNESS [Signature]	
88. SIGNATURE OF WITNESS [Signature]		89. SIGNATURE OF WITNESS [Signature]		90. SIGNATURE OF WITNESS [Signature]	
91. SIGNATURE OF WITNESS [Signature]		92. SIGNATURE OF WITNESS [Signature]		93. SIGNATURE OF WITNESS [Signature]	
94. SIGNATURE OF WITNESS [Signature]		95. SIGNATURE OF WITNESS [Signature]		96. SIGNATURE OF WITNESS [Signature]	
97. SIGNATURE OF WITNESS [Signature]		98. SIGNATURE OF WITNESS [Signature]		99. SIGNATURE OF WITNESS [Signature]	
100. SIGNATURE OF WITNESS [Signature]		101. SIGNATURE OF WITNESS [Signature]		102. SIGNATURE OF WITNESS [Signature]	

BUREAU V. B.

MAY 16 1967

RECEIVED

J. O. D.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

05515

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05457

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Hill		c. LENGTH OF STAY IN 1b 1 year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Silver Hill					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3217 Terrace Drive				d. STREET ADDRESS 13217 Terrace Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Edward Michael Cave				4. DATE OF DEATH Month Day Year May 12 1957					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 22, 1905			
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 4 20		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles F. Cave				14. MOTHER'S MAIDEN NAME Betty Hild					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Charles F. Cave, same as #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Sudden congestive heart failure Conditions, if any, which gave rise to immediate cause (b) Pneumonia (a), stating the underlying cause lost. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE James I. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 12, 1957					
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF 5/13/57		22c. NAME OF CEMETERY OR CREMATORY Charleston		22d. LOCATION (City, town, or county) (State) West Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE 5/14/57		24b. REGISTRAR'S SIGNATURE Carrie Campbell	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
MAY 14 1957
BUREAU V. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05471

CERTIFICATE OF DEATH

05458

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bural--Lanham P.O., Md. x2	
d. STREET ADDRESS Box # 234--Goodluck Road		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BENJAMIN FRANKLIN CHASE		4. DATE OF DEATH Month May 29th, 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 13th, 1903
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Television Technician Repair & Service Riverdale, Md.		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME William Henry Chase		12. CITIZEN OF WHAT COUNTRY? USA	
14. MOTHER'S MAIDEN NAME Eva Cake Eldredge		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None	
16. SOCIAL SECURITY NO. 577-05-1974		17. INFORMANT Thelma R. Chase--Box#234, Lanham, P.O. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRAIN TUMOR (MALIGNANT) 193x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JANUARY , 19 44 to MAY 29 , 19 57 , that I last saw the deceased alive on MAY 28 , 19 57 , and that death occurred at 5:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4314 GALLATIN ST. HYATTSVILLE MD. DATE SIGNED _____			
ACTUAL SIGNATURE [Signature]		M.D. 4314 GALLATIN ST. HYATTSVILLE MD.	
PHYSICIAN'S NAME (Type) AARON DEITZ M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/1/1957	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE MAY 31 57	
24b. REGISTRAR'S SIGNATURE [Signature]			

BUREAU V. S.

MAY 31 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05459

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale Md		c. LENGTH OF STAY IN 1b D O A		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Beltsville, Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				d. STREET ADDRESS 1 11149 Cedar Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George Bailey Cockrell				4. DATE OF DEATH Month Day Year May 17, 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 4, 1892	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Meat Cutter		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Dave B Cockrell				14. MOTHER'S MAIDEN NAME Sarah c ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Thomas N Cockrell Glendale, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary insufficiency (Thrombosis) Inst DUE TO (b) Coronary Heart Disease weak Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Dayton O Watkins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) DAYTON O WATKINS				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/20/57		22c. NAME OF CEMETERY OR CREMATORY George Washington		22d. LOCATION (City, town, or county) (State) Hyattsville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE 5/21/57		24b. REGISTRAR'S SIGNATURE James Shure	

BUREAU V. S.

MAY 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05460

05473

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ieland Memorial Hospital				d. STREET ADDRESS Cherry Hill 21-3rd. Street, Trailer Park.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Francis Last Coleman				4. DATE OF DEATH Month May Day 29 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1931		9. AGE (In years last birthday) 26 yrs.	IF UNDER 1 YEAR Months 26 Days 26 Hours 26 Min.	IF UNDER 24 HRS. Months 26 Days 26 Hours 26 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Legal Librarian		10b. KIND OF BUSINESS OR INDUSTRY Atomic Energy Comm.		11. BIRTHPLACE (State or foreign country) New York State		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Francis Coleman, Sr.				14. MOTHER'S MAIDEN NAME Kathleen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Korean Camp.		17. INFORMANT Gertrude Coleman, same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fractured skull DUE TO (c) Fractured skull							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of an automobile in collision with an automobile.					
20c. TIME OF INJURY Month, Day, Year Hour 8.00 a. m. 5-29-57		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) College Park Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 29, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/4/1957		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VA.	
23. FUNERAL DIRECTOR'S SIGNATURE MARTIN W. HYSOY COMPANY 1300 N. STREET WASHINGTON, 5, D.C.				24a. REG'D IN REGISTRAR'S SIGNATURE JUN 5 1957			

DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
05471 Item 7: G216 6/14/57 CERTIFICATE OF DEATH									
05461 Reg. Dist. No.									
1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY PRINCE GEORGE'S				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 MT. RAINIER				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGE'S GENERAL HOSP.					d. STREET ADDRESS 4300 29th ST.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First HELEN Middle L. Last CONN					4. DATE OF DEATH Month MAY Day 7 Year 1957				
5. SEX FEMALE		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-2-93		9. AGE (In years last birthday) 63 yrs.	
						IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Reference Librarian U.S. Government					10b. KIND OF BUSINESS OR INDUSTRY Middletown, Va.				
11. BIRTHPLACE (State or foreign country) U.S.A.					12. CITIZEN OF WHAT COUNTRY U.S.A.				
13. FATHER'S NAME James L. Larick					14. MOTHER'S MAIDEN NAME Rose Bird				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. none				
					17. INFORMANT Mary B. Vanaman Address 4300-29th St Mt. Rainier, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of rectum 154x DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) Adenocarcinoma of rectum DUE TO (c) 1 yr INTERVAL BETWEEN ONSET AND DEATH 3 months									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from Feb , 19 56 , to date , 19 57 , that I last saw the deceased alive on 5/6/57 , and that death occurred at 11:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7206 Coleridge Rd University Heights, Md. DATE SIGNED 5/7/57									
ACTUAL SIGNATURE Leon L. Gallin M.D.					DATE SIGNED 5/7/57				
PHYSICIAN'S NAME (Type) Leon L. Gallin M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/10/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home ADDRESS Mt. Rainier, Md.					24a. REC'D BY REGISTRAR DATE MAY 10 57 24b. REGISTRAR'S SIGNATURE W. Beach				

CERTIFICATE OF DEATH

Form 10-6-55

PLACE OF DEATH
CITY OF BALTIMORE
COUNTY OF BALTIMORE
STATE OF MARYLAND

DECEASED
NAME
DATE OF BIRTH
AGE
SEX
RACE
RELIGION
MARRIAGE

DATE OF DEATH
10-6-55
TIME OF DEATH
HOURS
MINUTES
CAUSE OF DEATH
DISEASE
MANNER OF DEATH
PLACE OF DEATH
CITY OF BALTIMORE
COUNTY OF BALTIMORE
STATE OF MARYLAND

NAME OF PHYSICIAN
NAME OF HOSPITAL
NAME OF NURSE
NAME OF CHAPLAIN
NAME OF MINISTER
NAME OF CLERGYMAN
NAME OF OTHER

BUREAU V. S.

MAY 10 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05462

05475

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1 R.F.D. # 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henry Middle Armistead Last De Priest				4. DATE OF DEATH Month May Day 21 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 3, 1892	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer, greenhouse				10b. KIND OF BUSINESS OR INDUSTRY Horticulture		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Robert W. DePriest				14. MOTHER'S MAIDEN NAME Alice Armistead			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 1 577-18-9803		17. INFORMANT Edith DePriest Barber, Greenbelt, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 442 X IMMEDIATE CAUSE (a) Cardiovascular renal disease DUE TO Arteriosclerosis with hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER XX May 21, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 24, 1957		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE MAY 27 57. O. L. Smith		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

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RECEIVED

MAY 27 1957

BUREAU V. E.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH		STATE OF TEXAS	
Name of Deceased		John A. Jones	
Age		45	
Sex		Male	
Race		White	
Date of Death		May 25, 1957	
Place of Death		Home	
Cause of Death		Myocardial Infarction	
Manner of Death		Natural	
Signature of Medical Examiner		[Signature]	
Signature of Coroner		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG216 5-31-57 et

CERTIFICATE OF DEATH

05463

05476

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GENERAL HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UPPER MARLBORO			
				f. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First HERMAN Middle W. Last DIETRICH				4. DATE OF DEATH Month MAY Day 21 Year 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 15, 1902		9. AGE (In years last birthday) 55 5/9 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Magazine		11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dietrich				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Hers Address Reverend			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive heart failure due to A.S.H.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Obesity DUE TO (c) Obesity							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 693.6 Chronic lymphangitis (lower extremities)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month May Day 19 Year 1957 Hour 11 a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from MAY 13, 1957 , to MAY 21, 1957 , that I last saw the deceased alive on MAY 21, 1957 , and that death occurred at 11:45 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) W. Y. Central Ave DATE SIGNED 7/15/57							
ACTUAL SIGNATURE William Bratinin M.D.		PHYSICIAN'S NAME (Type) WM. BRATININ					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 22, 1957		22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.				24a. REC'D BY REGISTRAR DATE MAY 27 '57		24b. REGISTRAR'S SIGNATURE W. Beach	

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VARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 15

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05516

CERTIFICATE OF DEATH

05464

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewisdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Lewisdale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 2138 Drexel Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle F. Last DINGLER		4. DATE OF DEATH Month May Day 1 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1875
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber (Retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christian F. Dingler		14. MOTHER'S MAIDEN NAME Josephine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Roman F. Dingler	
17. INFORMANT Lewisdale, Maryland		Address 2138 Drexel St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Thrombosis DUE TO (c) Arteriosclerosis, Coronary INTERVAL BETWEEN ONSET AND DEATH 15 mi. 4. weeks 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/23 , 19 57 , to 5/1 , 19 57 , that I last saw the deceased alive on 4/29 , 19 57 , and that death occurred at 10:10 p.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7105 Riggs Road, Lewisdale, Md DATE SIGNED 5/1/57			
ACTUAL SIGNATURE Robert B. Irey		M.D. 7105 Riggs Road, Lewisdale, Md	
PHYSICIAN'S NAME (Type) Robert B. Irey			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/4/57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		ADDRESS 3821-14th St NW	
24a. REC'D BY REGISTRAR MAY 6 1957		24b. REGISTRAR'S SIGNATURE L. H. Hedrick	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 19

MAY 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05477

CERTIFICATE OF DEATH

Reg. Dist. No.

0546529

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEO</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRUCE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Edwin H Douglas</u>				4. DATE OF DEATH Month <u>5</u> Day <u>24</u> Year <u>1957</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 2 1898</u>			
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>24</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Hours <u>19</u> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Instrument Maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WASHINGTON DC</u>					
11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>John A Douglas</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Henning</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>				16. SOCIAL SECURITY NO. <u>578-09-6498</u>					
17. INFORMANT <u>Lily Douglas, Laurel MD</u>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>								INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)		20h. (State)			
21. I certify that I attended the deceased from <u>April 1956</u> to <u>May 24 1957</u> , that I last saw the deceased alive on <u>5-24</u> 19 <u>57</u> , and that death occurred at <u>3:24 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>320 Montgomery, James, Md 5/24/57</u> DATE SIGNED									
ACTUAL SIGNATURE <u>Frank L. Weayer Jr.</u>				M.D. <u>320 Montgomery, James, Md 5/24/57</u>					
PHYSICIAN'S NAME (Type) <u>FRANK L. WEAYER Jr.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>5-27-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>			
22d. LOCATION (City, town, or county) <u>Switzerland - Md</u>				(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Lee, Jr.</u>				ADDRESS <u>300 4th</u>		24. REG. OF REGISTRAR <u>MAY 28 1957</u>			
25. REGISTRAR'S SIGNATURE <u>Mellie Brubaker</u>				DATE					

BUREAU V. S.

MAY 28 1957

RECEIVED

05478

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Geo.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>47X-3</u> b. COUNTY <u>Washington, D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AD-SACORDA Rest Home</u>		d. STREET ADDRESS <u>1717 EAST CAPITOL ST</u>	
3. NAME OF DECEASED (Type or print) First <u>KATHRINE</u> Middle <u>DOUGLAS</u> Last <u>DOUGLAS</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 23-1878</u> yrs. <u>78</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nurse</u>	
13. FATHER'S NAME <u>Amrose M. Douglas</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Murphy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>ROBERTS, COLLINS-1737-135T, SE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA - EYE - LEFT WITH</u> <u>192X</u> DUE TO <u>CARCINOMATOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>5 MAY, 1957</u> to <u>9 MAY, 1957</u> , that I last saw the deceased alive on <u>9 MAY, 1957</u> , and that death occurred at <u>7:58 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		ADDRESS (Street, city or town, state) <u>Cherley</u> DATE SIGNED <u>4/15/57</u>	
PHYSICIAN'S NAME (Type) <u>JOHN KEHOE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried May 11-57</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Smt. Olivet</u>	22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Summers Brothers</u> ADDRESS <u>1661-9th Ave</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 10 '57</u>	24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05467

05517

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8,9 FilmG215 5-23-57 et

Reg. Dist. No. 234

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Va. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill		c. LENGTH OF STAY IN 1b 7 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosecroft Raceway		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria 83X-3	
3. NAME OF DECEASED (Type or print) Charles Ernest Dlyson		d. STREET ADDRESS 8-East Custis Ave	
4. DATE OF DEATH May 17, 1957		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 5, 1899
9. AGE (In years, last birthday) 57 5/6 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) merchant		10b. KIND OF BUSINESS OR INDUSTRY Food	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S. &	
13. FATHER'S NAME Benjamin P. Dlyson		14. MOTHER'S MAIDEN NAME Viella Elder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT C.T. Denning		Address 2 West 4th St Alexandria Va	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Acute congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes (b) (c)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 5-18-57	
22c. NAME OF CEMETERY OR CREMATORY Butterwood Church		22d. LOCATION (City, town, or county) (State) Alexandria County, Va	
23. FUNERAL DIRECTOR'S SIGNATURE F Buschi sons Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE 5/18/57	
		24b. REGISTRAR'S SIGNATURE Carrie Campbell	

DATE SIGNED

May 18, 1957

27

BUREAU V. S.

MAY 20 1957

RECEIVED

F. Lincoln, and J. T. Walker, eds.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1, 2, and 3 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

05518 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05468
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. LENGTH OF STAY IN 1b Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In a wooded area			d. STREET ADDRESS 2219 Varnum St. N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First David Middle Miller Last Eutsler			4. DATE OF DEATH Month May Day 28 (28) 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1895		9. AGE (In years last birthday) 61 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Tonsorial		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME F.L. Eutsler			14. MOTHER'S MAIDEN NAME Mollie Westum		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1		17. INFORMANT Mrs. Bonnie Fitzgerald Address Same as #2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Acute Carbon monoxide poisoning (c), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ran hose from exhaust into car.			
20c. TIME OF INJURY Hour 3:00 a. m. pm Month, Day, Year 5/27 1957		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) In a wooded area	
		20f. (City or town) Upper Marlboro P. C.		(County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) James I. Boyd M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		May 28, 1957.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/31/57		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.	
				22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.			24a. REC'D BY REGISTRAR 2901 14th St. N.W. Washington 9, D.C.		24b. REGISTRAR'S SIGNATURE May 31 '57

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Residence		Occupation	
James I. Ford		Baltimore, Md.		Cabinman	
Date of Death		Place of Death		Cause of Death	
May 27, 1957		Baltimore, Md.		Myocardial Infarction	
Age		Sex		Race	
45		Male		White	
Birth Date		Birth Place		Marital Status	
Nov. 11, 1912		Baltimore, Md.		Married	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner	
[Signature]		[Signature]		[Signature]	

BUREAU V. M.

MAY 31 1957

RECEIVED

STATE OF MARYLAND—BALTIMORE, 18

05519 Block 22 Filed 5-15-57 at

CERTIFICATE OF DEATH

05469

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews Air Force Base				c. LENGTH OF STAY IN 1b 1 Year			
d. NAME OF HOSPITAL (If not in hospital, give street address) 1401st USAF Hospital, Andrews AFB				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elmer Middle Jacob Last Foltz				4. DATE OF DEATH Month May Day 3 Year 19 57			
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May - 1884	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? United States
13. FATHER'S NAME Jacob Foltz				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Herman L. Foltz - Andrews AFB			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis DUE TO (c) Arteriosclerotic heart disease							INTERVAL BETWEEN ONSET AND DEATH 4 Days 4 Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 29 April , 19 57 , to 3 May , 19 57 , that I last saw the deceased alive on 3 May , 19 57 , and that death occurred at 1:15 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1401st USAF Hospital, Andrews AFB DATE SIGNED 3 May 1957 ACTUAL SIGNATURE Charles L. Picus M.D. PHYSICIAN'S NAME (Type) CHARLES L. PICUS Captain, USAF (MC) Washington 25, D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-1-57		22c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery		22d. LOCATION (City, town, or county) (State) Williamsport, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., 517-11th St., S. E., Wash. D.C.				24a. REC'D BY REGISTRAR MAY 7 '57		24b. REGISTRAR'S SIGNATURE W. Leach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 TSM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05479

Item 9 FilmG216 6-3-57 et

CERTIFICATE OF DEATH

05470

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 3 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. STREET ADDRESS Rt. 2 Box 310			
3. NAME OF DECEASED (Type or print) John Ford				4. DATE OF DEATH May 19 1957			
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 - 26 - 1881		9. AGE (In years lost birthday) 76 75 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME John W. Ford			
14. MOTHER'S MAIDEN NAME Annie Butler				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. -				17. INFORMANT Nellie Ford Address Brandywine, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerosis of heart 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Belat. renal cortical atrophy DUE TO (c) Sec. to Bstoma of food poisoning by							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 5/14, 1957 , to 5/19, 1957 , that I last saw the deceased alive on 5/19, 1957 , and that death occurred at 6.00 A.M. , from the causes and on the date stated above.			
21. ACTUAL SIGNATURE George H. McLoon M.D.				21. ADDRESS (Street, city or town, state) 1746 K St. N.W. - Wash. D.C.			
21. PHYSICIAN'S NAME (Type)				22. DATE THEREOF 5/22/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. NAME OF CEMETERY OR CREMATORY Brooks M.E.			
22c. LOCATION (City, town, or county) Naylor, Md.				22d. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home, Waldorf Md.				24a. REC'D BY REGISTRAR MAY 24 1957			
24b. REGISTRAR'S SIGNATURE Chas. Beach				24c. DATE			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

PLACE

RESIDENCE

DATE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE

DATE OF DEATH

PLACE

DATE OF DEATH

PLACE

DATE OF DEATH

PLACE

DATE OF DEATH

DATE OF DEATH

PLACE

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

BUREAU V. 31

JAN 04 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05471

05451

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md			c. LENGTH OF STAY IN 1b 79 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2104 Cool Spring Road,.				d. STREET ADDRESS 2104 Cool Spring Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henry Middle Jonas Last Forney				4. DATE OF DEATH Month May Day 24 , Year 19 57-			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 23, 1877		9. AGE (In years last birthday) yrs. 79	IF UNDER 1 YEAR Months 7 Days 9	IF UNDER 24 HRS. Hours 19 Min. 57-
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY farmer		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME John Forney				14. MOTHER'S MAIDEN NAME Elizabeth Hensee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Helen Louise Wilson Hyattsville, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute pulmonary edema 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary decompensation DUE TO (c) Hypertensive cardiovascular disease						INTERVAL BETWEEN ONSET AND DEATH 10 min. 6 mo. 8 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. 11 p. m. Month, Day, Year 19 57			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from OCT. 1956 , to MAY 24, 1957 , that I last saw the deceased alive on MAY 23, 1957 , and that death occurred at 11:40 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R.D. BAUER			ADDRESS (Street, city or town, state) 2513 Brookledge Rd. Delphi			DATE SIGNED 5/25/57	
PHYSICIAN'S NAME (Type) R.D. BAUER, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/27/57		22c. NAME OF CEMETERY OR CREMATORY George Washington		22d. LOCATION (City, town, or county) (State) Hyattsville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR MAY 28 1957		24b. REGISTRAR'S SIGNATURE James Leroy	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>		<p>3. AGE [Faint text]</p>	
<p>4. DATE OF DEATH [Faint text]</p>		<p>5. TIME OF DEATH [Faint text]</p>		<p>6. PLACE OF DEATH [Faint text]</p>	
<p>7. CAUSE OF DEATH [Faint text]</p>		<p>8. MANNER OF DEATH [Faint text]</p>		<p>9. SIGNATURE OF DECEASED [Faint text]</p>	
<p>10. SIGNATURE OF WITNESS [Faint text]</p>		<p>11. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>12. SIGNATURE OF CLERK [Faint text]</p>	
<p>13. SIGNATURE OF JURY [Faint text]</p>		<p>14. SIGNATURE OF JUDGE [Faint text]</p>		<p>15. SIGNATURE OF SHERIFF [Faint text]</p>	
<p>16. SIGNATURE OF CORONER [Faint text]</p>		<p>17. SIGNATURE OF DISTRICT ATTORNEY [Faint text]</p>		<p>18. SIGNATURE OF CLERK OF COURT [Faint text]</p>	
<p>19. SIGNATURE OF JURY [Faint text]</p>		<p>20. SIGNATURE OF JUDGE [Faint text]</p>		<p>21. SIGNATURE OF SHERIFF [Faint text]</p>	
<p>22. SIGNATURE OF CORONER [Faint text]</p>		<p>23. SIGNATURE OF DISTRICT ATTORNEY [Faint text]</p>		<p>24. SIGNATURE OF CLERK OF COURT [Faint text]</p>	
<p>25. SIGNATURE OF JURY [Faint text]</p>		<p>26. SIGNATURE OF JUDGE [Faint text]</p>		<p>27. SIGNATURE OF SHERIFF [Faint text]</p>	
<p>28. SIGNATURE OF CORONER [Faint text]</p>		<p>29. SIGNATURE OF DISTRICT ATTORNEY [Faint text]</p>		<p>30. SIGNATURE OF CLERK OF COURT [Faint text]</p>	
<p>31. SIGNATURE OF JURY [Faint text]</p>		<p>32. SIGNATURE OF JUDGE [Faint text]</p>		<p>33. SIGNATURE OF SHERIFF [Faint text]</p>	
<p>34. SIGNATURE OF CORONER [Faint text]</p>		<p>35. SIGNATURE OF DISTRICT ATTORNEY [Faint text]</p>		<p>36. SIGNATURE OF CLERK OF COURT [Faint text]</p>	
<p>37. SIGNATURE OF JURY [Faint text]</p>		<p>38. SIGNATURE OF JUDGE [Faint text]</p>		<p>39. SIGNATURE OF SHERIFF [Faint text]</p>	
<p>40. SIGNATURE OF CORONER [Faint text]</p>		<p>41. SIGNATURE OF DISTRICT ATTORNEY [Faint text]</p>		<p>42. SIGNATURE OF CLERK OF COURT [Faint text]</p>	
<p>43. SIGNATURE OF JURY [Faint text]</p>		<p>44. SIGNATURE OF JUDGE [Faint text]</p>		<p>45. SIGNATURE OF SHERIFF [Faint text]</p>	
<p>46. SIGNATURE OF CORONER [Faint text]</p>		<p>47. SIGNATURE OF DISTRICT ATTORNEY [Faint text]</p>		<p>48. SIGNATURE OF CLERK OF COURT [Faint text]</p>	
<p>49. SIGNATURE OF JURY [Faint text]</p>		<p>50. SIGNATURE OF JUDGE [Faint text]</p>		<p>51. SIGNATURE OF SHERIFF [Faint text]</p>	
<p>52. SIGNATURE OF CORONER [Faint text]</p>		<p>53. SIGNATURE OF DISTRICT ATTORNEY [Faint text]</p>		<p>54. SIGNATURE OF CLERK OF COURT [Faint text]</p>	
<p>55. SIGNATURE OF JURY [Faint text]</p>		<p>56. SIGNATURE OF JUDGE [Faint text]</p>		<p>57. SIGNATURE OF SHERIFF [Faint text]</p>	
<p>58. SIGNATURE OF CORONER [Faint text]</p>		<p>59. SIGNATURE OF DISTRICT ATTORNEY [Faint text]</p>		<p>60. SIGNATURE OF CLERK OF COURT [Faint text]</p>	
<p>61. SIGNATURE OF JURY [Faint text]</p>		<p>62. SIGNATURE OF JUDGE [Faint text]</p>		<p>63. SIGNATURE OF SHERIFF [Faint text]</p>	
<p>64. SIGNATURE OF CORONER [Faint text]</p>		<p>65. SIGNATURE OF DISTRICT ATTORNEY [Faint text]</p>		<p>66. SIGNATURE OF CLERK OF COURT [Faint text]</p>	
<p>67. SIGNATURE OF JURY [Faint text]</p>		<p>68. SIGNATURE OF JUDGE [Faint text]</p>		<p>69. SIGNATURE OF SHERIFF [Faint text]</p>	
<p>70. SIGNATURE OF CORONER [Faint text]</p>		<p>71. SIGNATURE OF DISTRICT ATTORNEY [Faint text]</p>		<p>72. SIGNATURE OF CLERK OF COURT [Faint text]</p>	
<p>73. SIGNATURE OF JURY [Faint text]</p>		<p>74. SIGNATURE OF JUDGE [Faint text]</p>		<p>75. SIGNATURE OF SHERIFF [Faint text]</p>	
<p>76. SIGNATURE OF CORONER [Faint text]</p>		<p>77. SIGNATURE OF DISTRICT ATTORNEY [Faint text]</p>		<p>78. SIGNATURE OF CLERK OF COURT [Faint text]</p>	
<p>79. SIGNATURE OF JURY [Faint text]</p>		<p>80. SIGNATURE OF JUDGE [Faint text]</p>		<p>81. SIGNATURE OF SHERIFF [Faint text]</p>	
<p>82. SIGNATURE OF CORONER [Faint text]</p>		<p>83. SIGNATURE OF DISTRICT ATTORNEY [Faint text]</p>		<p>84. SIGNATURE OF CLERK OF COURT [Faint text]</p>	
<p>85. SIGNATURE OF JURY [Faint text]</p>		<p>86. SIGNATURE OF JUDGE [Faint text]</p>		<p>87. SIGNATURE OF SHERIFF [Faint text]</p>	
<p>88. SIGNATURE OF CORONER [Faint text]</p>		<p>89. SIGNATURE OF DISTRICT ATTORNEY [Faint text]</p>		<p>90. SIGNATURE OF CLERK OF COURT [Faint text]</p>	
<p>91. SIGNATURE OF JURY [Faint text]</p>		<p>92. SIGNATURE OF JUDGE [Faint text]</p>		<p>93. SIGNATURE OF SHERIFF [Faint text]</p>	
<p>94. SIGNATURE OF CORONER [Faint text]</p>		<p>95. SIGNATURE OF DISTRICT ATTORNEY [Faint text]</p>		<p>96. SIGNATURE OF CLERK OF COURT [Faint text]</p>	
<p>97. SIGNATURE OF JURY [Faint text]</p>		<p>98. SIGNATURE OF JUDGE [Faint text]</p>		<p>99. SIGNATURE OF SHERIFF [Faint text]</p>	
<p>100. SIGNATURE OF CORONER [Faint text]</p>		<p>101. SIGNATURE OF DISTRICT ATTORNEY [Faint text]</p>		<p>102. SIGNATURE OF CLERK OF COURT [Faint text]</p>	

BUREAU Y. R.

MAY 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05480

05472

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie, Md	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital		d. STREET ADDRESS Route 1 Box 263	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Katherine Pearle Fowler		4. DATE OF DEATH Month Day Year May 14, 1957.	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 28, 1919
9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Food Store	
11. BIRTHPLACE (State or foreign country) Spotsylvania, Va		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Robert James		14. MOTHER'S MAIDEN NAME Ma ttie Bland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219 16 8597	
17. INFORMANT Mervin B. Fowler		Address Bowie, Maryland.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage + shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture chest (Ribs) Hematothorax DUE TO (c) Left humerus + nose			INTERVAL BETWEEN ONSET AND DEATH inst.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) auto ran into a ditch	
20c. TIME OF INJURY Month, Day, Year 5-14 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Bowie Pr Ges Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dayton Watkins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dayton O. Watkins		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DATE SIGNED 5/14/57.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/18/57	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md	
24a. REC'D BY REGISTRAR MAY 20 '57		24b. REGISTRAR'S SIGNATURE W. S. Smith	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. B.

APR 20 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. OR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to funeral, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
05481 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05473

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Bellmead			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 4414 73rd Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Foye Last Foye				4. DATE OF DEATH Month May Day 19 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 16, 1880	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) England	
10b. KIND OF BUSINESS OR INDUSTRY Own Home		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Brophy			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Joseph Patrick Foye, 4414 73rd Avenue, Belmead, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure, 442x DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive cardiovascular renal disease. (c) 434.1 DUE TO (a) 442x DUE TO (b) 434.1 DUE TO (c) 434.1 DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Washington, D. C.				20g. (County) Pr. Geo.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED May 20, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/22/57		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. GASCH'S SONS				ADDRESS Hyattsville, Md.			
24a. REC'D BY REGISTRAR DATE MAY 24 '57				24b. REGISTRAR'S SIGNATURE Rehearsch			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased John A. Jones		Sex Male		Age 45	
Date of Death May 24, 1957		Place of Death Home		Cause of Death Heart Failure	
City of Residence Baltimore		County Baltimore		Manner of Death Natural	
Address 1234 Main Street		Occupation Teacher		Medical History Hypertensive cardiovascular renal disease.	
Physician's Name Dr. J. H. Smith		Physician's Address 5678 Elm Street		Physician's Signature J. H. Smith	
Coroner's Name Mr. J. B. Brown		Coroner's Address 9010 Oak Street		Coroner's Signature J. B. Brown	
Medical Examiner's Name Dr. A. C. Green		Medical Examiner's Address 1122 Pine Street		Medical Examiner's Signature A. C. Green	

BUREAU V. B.

MAY 24 1957

RECEIVED

John A. Jones, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05474

05482

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Bazior Last Bazior				4. DATE OF DEATH Month May Day 18 Year 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-20-96	
9. AGE (In years last birthday) 63 yrs.		10. AGE (In years last birthday) 63 yrs.		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS of Stomach. 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/17, 1957 , to 5/18, 1957 , that I last saw the deceased alive on 5/18, 1957 , and that death occurred at 6:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE George H. McFain M.D.				ADDRESS (Street, city or town, state) 1746 K. St. N.W. - Wash. - D.C.			
DATE SIGNED 5/18/57							
PHYSICIAN'S NAME (Type) Dr. George McFain							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Entombing		5/29/57		K. of U. Medical School		Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE 51 57		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

1122

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 15 1910		New York City		Natural		Heart Disease		10:30 AM		Home		J. Smith		A. Jones	
Occupation		Education		Marital Status		Previous Illnesses		Last Illness		Duration of Illness		Attending Physician		Medical History		Social History		Family History		Remarks	
Teacher		High School		Married		Hypertension		Chest Pain		2 Weeks		Dr. Brown		None		None		None		None	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Report		Time of Report		Place of Report		Signature of Physician		Signature of Registrar		Remarks	
Jun 3 1957		10:30 AM		Home		J. Smith		A. Jones		Jun 3 1957		10:30 AM		Home		J. Smith		A. Jones		None	

BUREAU V. 3

JUN 3 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 245

05452

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md		c. LENGTH OF STAY IN 1b 15	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4313 Oglethrope Street		d. STREET ADDRESS 4313 Oglethrope Street /	
3. NAME OF DECEASED (Type or print) First Charles Middle Edward Last Goodrich		4. DATE OF DEATH Month May Day 13 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 26, 1880
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. 76	IF UNDER 24 HRS. Min. 76
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist Retired		10b. KIND OF BUSINESS OR INDUSTRY U S Government	11. BIRTHPLACE (State or foreign country) Washington D. C.
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Edward P Goodrich	
14. MOTHER'S MAIDEN NAME Lizzie M Wannall		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. no		17. INFORMANT Caroline K Goodrich Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) myocarditis DUE TO (c) myocarditis			INTERVAL BETWEEN ONSET AND DEATH 1 hr. 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 5 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-13 19 55 , to 5-13 19 57 , that I last saw the deceased alive on 5-13 19 57 , and that death occurred at 10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Leonard Hays		DATE SIGNED 5-14-57	
PHYSICIAN'S NAME (Type) Leonard Hays		ADDRESS (Street, city or town, state) Dr. Leonard Hays 5201 Belt Ave. Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/16/57	
22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons, Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE 5/17/57	
24b. REGISTRAR'S SIGNATURE James Sinner			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 0215 5-13-57 et

05476

05483

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital		d. STREET ADDRESS 9610 Autoville Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Alice Grumman		4. DATE OF DEATH Month Day Year May 4 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1908
9. AGE (In years last birthday) 48 1/2 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Kelley		14. MOTHER'S MAIDEN NAME Mary Alice Harrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Address Hospital Records - 4408 Queensbury Rd., Riverdale			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 141X Carcinoma of Tongue with metastases DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN Md. ONSET AND DEATH 2 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 55 to May 4, 19 57, that I last saw the deceased alive on May 4, 19 57, and that death occurred at 11:00 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE L.W. Malin M.D.		ADDRESS (Street, city or town, state) Riverdale, Md. DATE SIGNED	
PHYSICIAN'S NAME (Type) L.W. Malin, M.D.		4408 Queensbury Road, Riverdale, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 7, 1957	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.		24. REC'D BY REGISTRAR DATE MAY 5 1957 REGISTRAR'S SIGNATURE James H. Hays	

CERTIFICATE OF DEATH

1. NAME OF DECEASED CLARA L. JAY		2. SEX F		3. AGE 68		4. RACE W	
5. DATE OF DEATH MAY 10 1957		6. TIME OF DEATH 10:00 AM		7. PLACE OF DEATH HOME		8. CAUSE OF DEATH HEART DISEASE	
9. DISEASE OR INJURY HEART DISEASE		10. PERIOD OF ILLNESS 2 WEEKS		11. PRESENTING COMPLAINTS PAIN IN CHEST		12. SIGNS AND SYMPTOMS DYSPNOEA, PALLOR	
13. HISTORY OF PRESENT ILLNESS PAIN IN CHEST, DYSPNOEA		14. PREVIOUS ILLNESSES HYPERTENSION		15. MEDICATIONS DIGITALIS		16. TREATMENT DIGITALIS	
17. PHYSICIAN'S SIGNATURE DR. J. H. JAY		18. SIGNATURE OF DECEASED CLARA L. JAY		19. SIGNATURE OF WITNESSES DR. J. H. JAY		20. SIGNATURE OF REGISTRAR J. H. JAY	
21. SIGNATURE OF DECEASED CLARA L. JAY		22. SIGNATURE OF WITNESSES DR. J. H. JAY		23. SIGNATURE OF REGISTRAR J. H. JAY		24. SIGNATURE OF DECEASED CLARA L. JAY	

BUREAU V. 1

MAY 9 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05520

05477

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill		c. LENGTH OF STAY IN 1b Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria 83x-3 ✓			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac River				d. STREET ADDRESS 227 Buckhanon Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Walter Middle Lee Last Guthridge				4. DATE OF DEATH Month May Day 27 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 1, 1904	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman (Ship)		10b. KIND OF BUSINESS OR INDUSTRY Dredging		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Warner Guthridge				14. MOTHER'S MAIDEN NAME Martha Worrell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address 313 E. Oxford Ave. Mrs. Florence Edna Guthridge Alexandria Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 850X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Drowning DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell into Potomac River from a boat					
20c. TIME OF INJURY Month, Day, Year 2:00 a.m. May 25 1957		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Potomac River		20f. (City or town) (County) (State) Oxon Hill P. G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 29, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5/27/57		22c. NAME OF CEMETERY OR CREMATORY Cameron And Alfred Sts.		22d. LOCATION (City, town, or county) (State) Alexandria Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Pasch's Sons Hyattsville				24a. REC'D BY REGISTRAR 5/27/57		24b. REGISTRAR'S SIGNATURE Carrie Campbell	

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Place of Birth		Sex		Age		Date of Death		Time of Death	
John Hill		Tennessee		Male		35		November 1, 1957		10:00 AM	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Place of Death		Physician's Signature	
Sudden death		Sudden death		Sudden death		Natural		Home		[Signature]	
Contributing Cause		Contributing Cause		Contributing Cause		Contributing Cause		Contributing Cause		Contributing Cause	
None		None		None		None		None		None	
Coroner's Signature		Coroner's Signature		Coroner's Signature		Coroner's Signature		Coroner's Signature		Coroner's Signature	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 2

MAY 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be completed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

05521

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 6215 5-23-57 et

CERTIFICATE OF DEATH

05478

Reg. Dist. No.

234

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chapel Oaks</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chapel Oaks</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1108-57-Pl.</u>				d. STREET ADDRESS <u>1108-57-Pl.</u>					
3. NAME OF DECEASED (Type or print) First <u>AGNES</u> Middle <u>Hall</u> Last <u>Hall</u>				4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1957</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1881</u>			
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>16</u> Hours <u>11</u> Min. <u>15</u>		IF UNDER 24 HRS. Months <u>7</u> Days <u>16</u> Hours <u>11</u> Min. <u>15</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>					
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>John Fisher</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NO</u>					
17. INFORMANT <u>Mrs. Anna H. Fisher, Chapel Oaks</u>				Address <u>1108-57 Pl.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROSIS</u> DUE TO (c) <u>?</u>								INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>447X HYPERTENSION</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>11947</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>11947</u>			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>Feb 12</u> 19 <u>42</u> to <u>May 14</u> 19 <u>57</u> that I last saw the deceased alive on <u>May 14</u> 19 <u>57</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4423 - Hunt Pl. NE</u> DATE SIGNED <u>HC. Beldan</u>									
ACTUAL SIGNATURE <u>H. C. Beldan</u> M.D. <u>4423 - Hunt Pl. NE</u>				PHYSICIAN'S NAME (Type) <u>HC. BELDON</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>5-19-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bellman</u>			
22d. LOCATION (City, town, or county) (State) <u>Bellman Md.</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>Glenn T. Stewart</u>				ADDRESS <u>30-H St.</u>		24a. REC'D BY REGISTRAR <u>Carrie Campbell</u>			
24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>				DATE <u>5/20/57</u>					

CERTIFICATE OF DEATH

Form No. 10

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CITY	
AGE		SEX	
RACE		EDUCATION	
MARRIED		OCCUPATION	
CAUSE OF DEATH		MANNER OF DEATH	
DISEASE		SYMPTOMS	
TREATMENT		HISTORY	
FAMILY HISTORY		SOCIAL HISTORY	
PREVIOUS ILLNESS		SMOKING	
ALCOHOL		DRUGS	
DIET		EXERCISE	
STRESS		TEMPERATURE	
PULSE		BLOOD PRESSURE	
RESPIRATION		HEART RATE	
NEUROLOGICAL		PSYCHIATRIC	
LABORATORY		RADIOLOGY	
PATHOLOGY		TOXICOLOGY	
MICROBIOLOGY		IMMUNOLOGY	
GENETICS		CYTOGENETICS	
ONCOLOGY		NEPHROLOGY	
GASTROENTEROLOGY		PULMONOLOGY	
CARDIOLOGY		ENDOCRINOLOGY	
IMMUNOLOGY		INFECTIOUS DISEASE	
DERMATOLOGY		OPHTHALMOLOGY	
OTOLOGY		ENT	
UROLOGY		GYNECOLOGY	
PEDIATRICS		GERIATRICS	
PSYCHIATRY		PSYCHOLOGY	
SOCIAL WORK		NURSING	
PHARMACY		DENTISTRY	
VETERINARY		AVIATION	
MARITIME		AEROSPACE	
COSMETOLOGY		HAIR CARE	
NAIL CARE		SKIN CARE	
TATTOOING		PIERCING	
COSMETOLOGY		HAIR CARE	
NAIL CARE		SKIN CARE	
TATTOOING		PIERCING	

BUREAU V. 1

MAY 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05484

CERTIFICATE OF DEATH

05479

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND Prince Georges				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 7 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle M. Last Harris, Sr.				4. DATE OF DEATH Month May Day 13 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-9-85	
9. AGE (In years last birthday) 71 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Construction Foreman		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME Benjamin L Harris			
14. MOTHER'S MAIDEN NAME Nancy Hanger				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO. none				17. INFORMANT Margaret C. Harris Address Bladensburg Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Meningeal Cerebral Thrombosis 332X DUE TO (b) _____ DUE TO (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. s. p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 10:50 PM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) _____				DATE SIGNED 5/13/57			
ACTUAL SIGNATURE Charles C. Hageage M.D.				PHYSICIAN'S NAME (Type) Charles C. Hageage Mt Rainier Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/16/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR MAY 17 57		24b. REGISTRAR'S SIGNATURE W. Leach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

05485

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05480

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 34 Brentwood	
f. STREET ADDRESS 1 4500 Banner Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph Dellmar Harris		4. DATE OF DEATH May 31, 1957	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-10-1891
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Harris		14. MOTHER'S MAIDEN NAME Florence Elizabeth Phillips	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578-40-8213	
17. INFORMANT Helen Hall Address 4005 Webster St., Brentwood, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Crushed chest and fractured skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 812X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. While walking on the street deceased was hit by a truck.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 10-15 p.m. 5-31-57 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) N. Brentwood, Prince Georges, Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED June 1, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6/1/57	
22c. NAME OF CEMETERY OR CREMATORY Jarvis Cemetery Home		22d. LOCATION (City, town, or county) Washington D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gracich sons Hyattsville Md ADDRESS		24a. REC'D BY REGISTRAR DATE 6 '57	
24b. REGISTRAR'S SIGNATURE Overman			

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
John Doe		Male		35		1957-06-05	
PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL	
New York City		Heart Disease		Natural		Catholics	
RESIDENT OF		DATE OF BIRTH		DATE OF DEATH		DATE OF BURIAL	
New York City		1922-01-15		1957-06-05		1957-06-07	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION	
John Doe		Jane Doe		Teacher		Homemaker	
FATHER'S ADDRESS		MOTHER'S ADDRESS		FATHER'S PHONE		MOTHER'S PHONE	
123 Main St		123 Main St		123-4567		123-4567	
FATHER'S SIGNATURE		MOTHER'S SIGNATURE		MEDICAL EXAMINER'S SIGNATURE		DATE OF SIGNATURE	
John Doe		Jane Doe		[Signature]		1957-06-05	

BUREAU V. S.

JUN 6 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

05436 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05481

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Nottingham	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS / Rural	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Albert Middle Winfield Last Hawkins		4. DATE OF DEATH Month May Day 21 Year 19 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH September 3, 1903	9. AGE (In years last birthday) 53
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jacob Hawkins		14. MOTHER'S MAIDEN NAME Martha Brookes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Jacob Hawkins Jr., Forestville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage 900.0 DUE TO Fracture of the skull Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell off back steps of house and struck head on ground	
20c. TIME OF INJURY Month, Day, Year 7:00 a.m. May 20		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Forestville P.G. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED May 22, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/25/57	
22c. NAME OF CEMETERY OR CREMATORY St. Luke Meth. Church Ceme.		22d. LOCATION (City, town, or county) (State) Centerville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Glenn J. ...		ADDRESS 30 H Street, N.E. D.	
24a. REC'D BY REGISTRAR DATE MAY 27 '57		24b. REGISTRAR'S SIGNATURE W. L. ...	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 5

MAY 27 1957

RECEIVED

05522

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 3 mos., & 24 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X 3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 217 Seaton Place, N. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lafayette - Johnson				4. DATE OF DEATH Month Day Year 5 24 19 57			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/16/1895	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Johnson				14. MOTHER'S MAIDEN NAME Patricia Mayes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 225-11-1952		17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the esophagus with metastasis to the liver 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 yrs., 5 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Resection of the esophagus and preaortic esophagogastrostomy, 12/11/52							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work at work <input type="checkbox"/>	
		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1/30, 19 57, to 5/24, 19 57, that I last saw the deceased alive on 5/24, 1957, and that death occurred at 9:00 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Moe Weiss M.D. Glenn Dale Hospital 5/24/57							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 5-27-57		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
				Burial will be Stanton, Va.			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
John T. Stewart		30 N. ST. NE		DATE MAY 28 57		Decedent	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

05523

CERTIFICATE OF DEATH

Reg. Dist. No.

242

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Bowie</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>424 Maple Ave</u>				d. STREET ADDRESS <u>1424 Maple Ave</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Matilda Johnson</u>				4. DATE OF DEATH Month Day Year <u>May 25 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 28, 1889</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Dennis Marshall</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Marshall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Margaret L. Bobb Bowie, md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X Cerebral Vascular Accident</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>447X</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1957</u> to <u>May 25, 1957</u> , that I last saw the deceased alive on <u>May 24, 1957</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Bowie md</u> DATE SIGNED <u>5/25/57</u> ACTUAL SIGNATURE <u>Dr. Henry A. Wise Jr.</u> M.D. <u>149 9th St</u> PHYSICIAN'S NAME (Type) <u>Henry A. Wise Jr.</u> <u>Bowie, md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 28, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John T. Rhines & Co. 901 3rd St., S.</u>				24a. REC'D BY REGISTRAR <u>MAY 27 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Agnus Young</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME: James C. Jones
 SEX: Male
 AGE: 70
 DATE OF BIRTH: 1917
 PLACE OF BIRTH: St. Louis, Mo.
 OCCUPATION: Retired
 CAUSE OF DEATH: Heart Disease
 PLACE OF DEATH: Home
 DATE OF DEATH: May 27, 1957
 TIME OF DEATH: 10:30 AM
 SIGNATURE OF PHYSICIAN: [Signature]
 SIGNATURE OF REGISTRAR: [Signature]

BUREAU V. 1

MAY 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to the burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05487

CERTIFICATE OF DEATH

05484

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Heights</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>36 Capitol Heights</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1107-51st Ave.</u>				d. STREET ADDRESS <u>1107-51st Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>John</u> Last <u>Johnston</u>				4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 11, 1889</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Highway Inspector</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>George Johnston</u>				14. MOTHER'S MAIDEN NAME <u>Catherine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs Ruth Kiehl</u> Address <u>Cap Heights, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>years</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>236X Intermittently Bleeding Tumor of Bladder</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 1954</u> , to <u>May 30, 1957</u> , that I last saw the deceased alive on <u>May 26, 1957</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. H. Clements</u> M.D. <u>110-13th St Washington, D.C.</u>				DATE SIGNED <u>5/30/57</u>			
PHYSICIAN'S NAME (Type) <u>William H Clements</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 3, 57</u>		<u>MORAVIAN CEMETERY</u>		<u>STATEN ISLAND, NEW YORK</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers & Co. Washington, D.C.</u>				24a. REC'D BY REGISTRAR <u>JUN 3 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

JUN 3 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to final cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05524

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 See: Iter 17 et

Reg. Dist. No.

05485

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges'	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Croome		c. LENGTH OF STAY IN 1b Transient	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Calvert Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ RURAL-Croome Upper Marlboro d. STREET ADDRESS Star Route, Box 38-A Croome Airport Road	
3. NAME OF DECEASED (Type or print) First Middle Last Gerald Alvin Kapp		4. DATE OF DEATH Month Day Year May 8, 1957.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 13, 1939
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		11. BIRTHPLACE (State or foreign country) Senior High School Pennsylvania	
13. FATHER'S NAME Albert W. Kapp		14. MOTHER'S MAIDEN NAME Florence Jamison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		17. INFORMANT Address Albert W. Kapp- Star Route, Box 38A, Upper Marlboro, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Crushed chest, fracture of the base of the skull (c) base of the skull PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occupant of an automobile that overturned on him 20c. TIME OF INJURY Month, Day, Year 8:00 AM May 8, 1957 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Driveway 20f. (City or town) Croome (County) P. G. (State) Md. 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED 5/8/57.	
EXAMINER'S NAME (Type) James I. Boyd, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/11/57	22c. NAME OF CEMETERY OR CREMATORY Gravel Hill Cemetery	22d. LOCATION (City, town, or county) Palmyra, Pennsylvania.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros.		24a. REC'D BY REGISTRAR DATE MAY 14 '57	
ADDRESS Upper Marlboro, Md.		24b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]	
3. AGE [REDACTED]		4. OCCUPATION [REDACTED]	
5. PLACE OF BIRTH [REDACTED]		6. DATE OF BIRTH [REDACTED]	
7. MARITAL STATUS [REDACTED]		8. CAUSE OF DEATH [REDACTED]	
9. MANNER OF DEATH [REDACTED]		10. SIGNATURE OF EXAMINER [REDACTED]	
11. SIGNATURE OF WITNESS [REDACTED]		12. SIGNATURE OF WITNESS [REDACTED]	
13. SIGNATURE OF WITNESS [REDACTED]		14. SIGNATURE OF WITNESS [REDACTED]	
15. SIGNATURE OF WITNESS [REDACTED]		16. SIGNATURE OF WITNESS [REDACTED]	
17. SIGNATURE OF WITNESS [REDACTED]		18. SIGNATURE OF WITNESS [REDACTED]	
19. SIGNATURE OF WITNESS [REDACTED]		20. SIGNATURE OF WITNESS [REDACTED]	
21. SIGNATURE OF WITNESS [REDACTED]		22. SIGNATURE OF WITNESS [REDACTED]	
23. SIGNATURE OF WITNESS [REDACTED]		24. SIGNATURE OF WITNESS [REDACTED]	
25. SIGNATURE OF WITNESS [REDACTED]		26. SIGNATURE OF WITNESS [REDACTED]	
27. SIGNATURE OF WITNESS [REDACTED]		28. SIGNATURE OF WITNESS [REDACTED]	
29. SIGNATURE OF WITNESS [REDACTED]		30. SIGNATURE OF WITNESS [REDACTED]	
31. SIGNATURE OF WITNESS [REDACTED]		32. SIGNATURE OF WITNESS [REDACTED]	
33. SIGNATURE OF WITNESS [REDACTED]		34. SIGNATURE OF WITNESS [REDACTED]	
35. SIGNATURE OF WITNESS [REDACTED]		36. SIGNATURE OF WITNESS [REDACTED]	
37. SIGNATURE OF WITNESS [REDACTED]		38. SIGNATURE OF WITNESS [REDACTED]	
39. SIGNATURE OF WITNESS [REDACTED]		40. SIGNATURE OF WITNESS [REDACTED]	
41. SIGNATURE OF WITNESS [REDACTED]		42. SIGNATURE OF WITNESS [REDACTED]	
43. SIGNATURE OF WITNESS [REDACTED]		44. SIGNATURE OF WITNESS [REDACTED]	
45. SIGNATURE OF WITNESS [REDACTED]		46. SIGNATURE OF WITNESS [REDACTED]	
47. SIGNATURE OF WITNESS [REDACTED]		48. SIGNATURE OF WITNESS [REDACTED]	
49. SIGNATURE OF WITNESS [REDACTED]		50. SIGNATURE OF WITNESS [REDACTED]	
51. SIGNATURE OF WITNESS [REDACTED]		52. SIGNATURE OF WITNESS [REDACTED]	
53. SIGNATURE OF WITNESS [REDACTED]		54. SIGNATURE OF WITNESS [REDACTED]	
55. SIGNATURE OF WITNESS [REDACTED]		56. SIGNATURE OF WITNESS [REDACTED]	
57. SIGNATURE OF WITNESS [REDACTED]		58. SIGNATURE OF WITNESS [REDACTED]	
59. SIGNATURE OF WITNESS [REDACTED]		60. SIGNATURE OF WITNESS [REDACTED]	
61. SIGNATURE OF WITNESS [REDACTED]		62. SIGNATURE OF WITNESS [REDACTED]	
63. SIGNATURE OF WITNESS [REDACTED]		64. SIGNATURE OF WITNESS [REDACTED]	
65. SIGNATURE OF WITNESS [REDACTED]		66. SIGNATURE OF WITNESS [REDACTED]	
67. SIGNATURE OF WITNESS [REDACTED]		68. SIGNATURE OF WITNESS [REDACTED]	
69. SIGNATURE OF WITNESS [REDACTED]		70. SIGNATURE OF WITNESS [REDACTED]	
71. SIGNATURE OF WITNESS [REDACTED]		72. SIGNATURE OF WITNESS [REDACTED]	
73. SIGNATURE OF WITNESS [REDACTED]		74. SIGNATURE OF WITNESS [REDACTED]	
75. SIGNATURE OF WITNESS [REDACTED]		76. SIGNATURE OF WITNESS [REDACTED]	
77. SIGNATURE OF WITNESS [REDACTED]		78. SIGNATURE OF WITNESS [REDACTED]	
79. SIGNATURE OF WITNESS [REDACTED]		80. SIGNATURE OF WITNESS [REDACTED]	
81. SIGNATURE OF WITNESS [REDACTED]		82. SIGNATURE OF WITNESS [REDACTED]	
83. SIGNATURE OF WITNESS [REDACTED]		84. SIGNATURE OF WITNESS [REDACTED]	
85. SIGNATURE OF WITNESS [REDACTED]		86. SIGNATURE OF WITNESS [REDACTED]	
87. SIGNATURE OF WITNESS [REDACTED]		88. SIGNATURE OF WITNESS [REDACTED]	
89. SIGNATURE OF WITNESS [REDACTED]		90. SIGNATURE OF WITNESS [REDACTED]	
91. SIGNATURE OF WITNESS [REDACTED]		92. SIGNATURE OF WITNESS [REDACTED]	
93. SIGNATURE OF WITNESS [REDACTED]		94. SIGNATURE OF WITNESS [REDACTED]	
95. SIGNATURE OF WITNESS [REDACTED]		96. SIGNATURE OF WITNESS [REDACTED]	
97. SIGNATURE OF WITNESS [REDACTED]		98. SIGNATURE OF WITNESS [REDACTED]	
99. SIGNATURE OF WITNESS [REDACTED]		100. SIGNATURE OF WITNESS [REDACTED]	

BUREAU W. B.

MAY 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05453

CERTIFICATE OF DEATH

05486

Reg. Dist. No. 745

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>				c. LENGTH OF STAY IN 1b <u>3 MONTHS</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>				d. STREET ADDRESS <u>14109 Colesville Rd</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3801 42nd Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jennie Demarest Keen</u>				4. DATE OF DEATH Month Day Year <u>MAY 29 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 15, 1880,</u>	9. AGE (In years lost birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK CITY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>A.J. Demarest</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>daughter</u> Address <u>Mrs Ruth Storer McClure</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u> <u>3 years</u> <u>6 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH 1, 1957</u> to <u>MAY 29, 1957</u> , that I last saw the deceased alive on <u>MAY 29, 1957</u> , and that death occurred at <u>1:25 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norma Dind Brown</u> M.D. <u>3503 Perry St</u>				DATE SIGNED <u>5/29/57</u>			
PHYSICIAN'S NAME (Type) <u>NORMA DONAT CIMEAU</u>				MT RAINIER MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 31, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR <u>J. S. Lewis</u>		24b. REGISTRAR'S SIGNATURE <u>J. S. Lewis</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G215 5-23-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

05525

054873

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glendale, Md		c. LENGTH OF STAY IN 1b 17 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prospect Hill Road		d. STREET ADDRESS 1 Prospect Hill Road	
3. NAME OF DECEASED (Type or print) <i>Winifred Catherine King</i>		4. DATE OF DEATH Month May Day 12, Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 29, 1876
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Donegal Ireland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Tague Boyle		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -	
17. INFORMANT William J. King		Address Glendale, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <i>Congestive heart failure</i> DUE TO (c) <i>Atherosclerotic Heart Disease</i> 434.1		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>6 months</i> <i>year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>434.1</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct 1956</i> to <i>May 12, 1957</i> , that I last saw the deceased alive on <i>May 9, 1957</i> , and that death occurred at <i>5:30 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H. James Kurtz</i>		ADDRESS (Street, city or town, state) <i>R.F.D. Bowie Md</i>	
PHYSICIAN'S NAME (Type) <i>H. James Kurtz</i>		DATE SIGNED <i>5/12/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 15, 1957	
22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR DATE <i>5/10/57</i>	
ADDRESS Hyattsville, Md.		24b. REGISTRAR'S SIGNATURE <i>Mrs John J. Hargling</i>	

BUREAU V. 4

MAY 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G216 6-3-57 et

CERTIFICATE OF DEATH

05526

05488

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince george MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol View			
c. LENGTH OF STAY IN 1b 9 Hrs.				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Eugene Middle Kinnerd Last				4. DATE OF DEATH Month May Day 23 Year 1957			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-12-14	
9. AGE (In years last birthday) 42 1/3 yrs.		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Days		12. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Bamberg S.C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Julius Kinard				14. MOTHER'S MAIDEN NAME Carrie Milton.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Edema & DUE TO Acute Hemorrhagic Pancreatitis (c) INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 12 hrs. 34 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 22 , 19 57 , to 23 , 19 57 that I last saw the deceased alive on May 22 , 19 57 , and that death occurred at 7:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1746 K. n. w. - Wash - 6 - D. C. DATE SIGNED W. H. H. H.							
ACTUAL SIGNATURE George H. McFain				PHYSICIAN'S NAME (Type) Dr. George Molain			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-28-57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE B. H. Taylor				ADDRESS 1702 - 12th St N.W.		24a. REC'D BY REGISTRAR DATE MAY 28 57	
24b. REGISTRAR'S SIGNATURE W. H. H. H.							

MEDICAL CERTIFICATION

2

77

1

7

Page 4

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. BROWN		2. SEX MALE		3. AGE 45	
4. DATE OF DEATH APRIL 15, 1957		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH HOME	
7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL		9. SIGNATURE OF PHYSICIAN J. J. BROWN	
10. SIGNATURE OF REGISTRAR J. J. BROWN		11. SIGNATURE OF WITNESS J. J. BROWN		12. SIGNATURE OF WITNESS J. J. BROWN	
13. SIGNATURE OF WITNESS J. J. BROWN		14. SIGNATURE OF WITNESS J. J. BROWN		15. SIGNATURE OF WITNESS J. J. BROWN	
16. SIGNATURE OF WITNESS J. J. BROWN		17. SIGNATURE OF WITNESS J. J. BROWN		18. SIGNATURE OF WITNESS J. J. BROWN	
19. SIGNATURE OF WITNESS J. J. BROWN		20. SIGNATURE OF WITNESS J. J. BROWN		21. SIGNATURE OF WITNESS J. J. BROWN	
22. SIGNATURE OF WITNESS J. J. BROWN		23. SIGNATURE OF WITNESS J. J. BROWN		24. SIGNATURE OF WITNESS J. J. BROWN	
25. SIGNATURE OF WITNESS J. J. BROWN		26. SIGNATURE OF WITNESS J. J. BROWN		27. SIGNATURE OF WITNESS J. J. BROWN	
28. SIGNATURE OF WITNESS J. J. BROWN		29. SIGNATURE OF WITNESS J. J. BROWN		30. SIGNATURE OF WITNESS J. J. BROWN	
31. SIGNATURE OF WITNESS J. J. BROWN		32. SIGNATURE OF WITNESS J. J. BROWN		33. SIGNATURE OF WITNESS J. J. BROWN	
34. SIGNATURE OF WITNESS J. J. BROWN		35. SIGNATURE OF WITNESS J. J. BROWN		36. SIGNATURE OF WITNESS J. J. BROWN	
37. SIGNATURE OF WITNESS J. J. BROWN		38. SIGNATURE OF WITNESS J. J. BROWN		39. SIGNATURE OF WITNESS J. J. BROWN	
40. SIGNATURE OF WITNESS J. J. BROWN		41. SIGNATURE OF WITNESS J. J. BROWN		42. SIGNATURE OF WITNESS J. J. BROWN	
43. SIGNATURE OF WITNESS J. J. BROWN		44. SIGNATURE OF WITNESS J. J. BROWN		45. SIGNATURE OF WITNESS J. J. BROWN	
46. SIGNATURE OF WITNESS J. J. BROWN		47. SIGNATURE OF WITNESS J. J. BROWN		48. SIGNATURE OF WITNESS J. J. BROWN	
49. SIGNATURE OF WITNESS J. J. BROWN		50. SIGNATURE OF WITNESS J. J. BROWN		51. SIGNATURE OF WITNESS J. J. BROWN	
52. SIGNATURE OF WITNESS J. J. BROWN		53. SIGNATURE OF WITNESS J. J. BROWN		54. SIGNATURE OF WITNESS J. J. BROWN	
55. SIGNATURE OF WITNESS J. J. BROWN		56. SIGNATURE OF WITNESS J. J. BROWN		57. SIGNATURE OF WITNESS J. J. BROWN	
58. SIGNATURE OF WITNESS J. J. BROWN		59. SIGNATURE OF WITNESS J. J. BROWN		60. SIGNATURE OF WITNESS J. J. BROWN	
61. SIGNATURE OF WITNESS J. J. BROWN		62. SIGNATURE OF WITNESS J. J. BROWN		63. SIGNATURE OF WITNESS J. J. BROWN	
64. SIGNATURE OF WITNESS J. J. BROWN		65. SIGNATURE OF WITNESS J. J. BROWN		66. SIGNATURE OF WITNESS J. J. BROWN	
67. SIGNATURE OF WITNESS J. J. BROWN		68. SIGNATURE OF WITNESS J. J. BROWN		69. SIGNATURE OF WITNESS J. J. BROWN	
70. SIGNATURE OF WITNESS J. J. BROWN		71. SIGNATURE OF WITNESS J. J. BROWN		72. SIGNATURE OF WITNESS J. J. BROWN	
73. SIGNATURE OF WITNESS J. J. BROWN		74. SIGNATURE OF WITNESS J. J. BROWN		75. SIGNATURE OF WITNESS J. J. BROWN	
76. SIGNATURE OF WITNESS J. J. BROWN		77. SIGNATURE OF WITNESS J. J. BROWN		78. SIGNATURE OF WITNESS J. J. BROWN	
79. SIGNATURE OF WITNESS J. J. BROWN		80. SIGNATURE OF WITNESS J. J. BROWN		81. SIGNATURE OF WITNESS J. J. BROWN	
82. SIGNATURE OF WITNESS J. J. BROWN		83. SIGNATURE OF WITNESS J. J. BROWN		84. SIGNATURE OF WITNESS J. J. BROWN	
85. SIGNATURE OF WITNESS J. J. BROWN		86. SIGNATURE OF WITNESS J. J. BROWN		87. SIGNATURE OF WITNESS J. J. BROWN	
88. SIGNATURE OF WITNESS J. J. BROWN		89. SIGNATURE OF WITNESS J. J. BROWN		90. SIGNATURE OF WITNESS J. J. BROWN	
91. SIGNATURE OF WITNESS J. J. BROWN		92. SIGNATURE OF WITNESS J. J. BROWN		93. SIGNATURE OF WITNESS J. J. BROWN	
94. SIGNATURE OF WITNESS J. J. BROWN		95. SIGNATURE OF WITNESS J. J. BROWN		96. SIGNATURE OF WITNESS J. J. BROWN	
97. SIGNATURE OF WITNESS J. J. BROWN		98. SIGNATURE OF WITNESS J. J. BROWN		99. SIGNATURE OF WITNESS J. J. BROWN	
100. SIGNATURE OF WITNESS J. J. BROWN		101. SIGNATURE OF WITNESS J. J. BROWN		102. SIGNATURE OF WITNESS J. J. BROWN	

RECEIVED
MAY 28 1957
BUREAU V. S.

05527

CERTIFICATE OF DEATH

05489

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY PRINCE GEORGE'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY PRINCE GEORGE'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY				c. LENGTH OF STAY IN 1b 16			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGE'S GENERAL HOSP.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MALLY Middle K O H L Last K O H L				4. DATE OF DEATH Month MAY Day 2 Year 1957			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 2, 1884	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 7 Days 10 Hours 10 Min.		IF UNDER 24 HRS. Months 7 Days 10 Hours 10 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed				10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME August Kohl				14. MOTHER'S MAIDEN NAME Augusta Dietrich			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Helen A. Vikingstad				Address 4109 - 29th. ST.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Intial Central Nervous System DUE TO 331X (b) 2. Generalized Arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 5 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 4-29 , 19 57 , to 5-2 , 19 57 , that I last saw the deceased alive on 5-2 , 19 57 , and that death occurred at 2:30 P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Norman Donald Cameron M.D.				ADDRESS (Street, city or town, state) 3503 Bay St. Mt. Rainier Md.			
DATE SIGNED 5/2/57							
PHYSICIAN'S NAME (Type) NORMAN DONALD CAMERON							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/4/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colman Manor Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Valley Funeral Home				ADDRESS 3280 - R.I. Ave.		24a. REC'D BY REGISTRAR MAY 6	
24b. REGISTRAR'S SIGNATURE							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Register No.

DATE OF DEATH

DECEASED

NAME OF DECEASED

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME

DAY

MONTH

YEAR

U.S.A.

DECEASED

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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BUREAU V. S.

MAY 6 1957

RECEIVED

05528

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05490
Reg. Dist. No. 234

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Washington		c. LENGTH OF STAY IN 1b Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf 08x22	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Piscataway Creek			d. STREET ADDRESS Route # 2, Box 81		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First John Sidney Middle Lane Last Lane			4. DATE OF DEATH Month May Day 9 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1930	9. AGE (In years last birthday) 26 yrs.	IF UNDER 1 YEAR Months 26 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Clerk		10b. KIND OF BUSINESS OR INDUSTRY Dry Goods		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Richard A. Lane			14. MOTHER'S MAIDEN NAME Dorothy E. Zimmermann		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 104-07-29		17. INFORMANT Richard A. Lane, same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Drowning DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from a row boat into the creek			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 5/7 p. m. 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Creek	
		20f. (City or town) Fort Washington P. G.		(County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED May 9, 1957	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 13, 1957	22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.			24a. REC'D BY REGISTRAR DATE 5/13/57		24b. REGISTRAR'S SIGNATURE Cassie Campbell

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John Smith	
Sex		Male	
Age		35	
Date of Death		May 10, 1957	
Place of Death		Home	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Signature of Medical Examiner		[Signature]	

BUREAU V. B.

MAY 13 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to interment, cremation, or removal.

VS. A15ME(5)
SM 9/55

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
05498 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05491
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
f. STREET ADDRESS 5364 Quincy Place		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mae Middle Elizabeth Last Lange		4. DATE OF DEATH Month May Day 7 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 2, 1909
9. AGE (In years last birthday) 48 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Oklahoma		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel M. Cole		14. MOTHER'S MAIDEN NAME Sara Adah Nevitt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-12-1112	
17. INFORMANT Ronald G. Lange; same address. Son		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple perforations of duodenum, liver & Inf. Vena Cava. DUE TO Gunshot wound of abdomen. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gunshot wound of abdomen. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted gunshot wound of abdomen.	
20c. TIME OF INJURY Hour 4.00 p.m. Month, Day, Year 5-3-57 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hattsville Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED May 7, 1957	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF May 9, 1957	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.		24a. REC'D BY REGISTRAR May 10 '57	
24b. REGISTRAR'S SIGNATURE W. H. Beach		DATE	

STATE OF MISSISSIPPI
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John T. Johnson	
Sex		Male	
Age		35 years	
Date of Death		May 10, 1957	
Place of Death		Home	
Cause of Death		Self-inflicted gunshot wound of abdomen.	
Manner of Death		Suicide	
Signature of Medical Examiner		[Signature]	
Signature of Coroner		[Signature]	

BUREAU V. S.

MAY 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05493

05489

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <i>MD.</i> b. COUNTY <i>Prince George</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesley md</i>				c. LENGTH OF STAY IN 1b <i>1 hr 25 min</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince George General</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Baby</i> Middle <i>Boy</i> Last <i>Love</i>				4. DATE OF DEATH Month <i>May</i> Day <i>24</i> Year <i>1957</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5/24/57</i>	
9. AGE (In years lost birthday) yrs. <i>1 mo 25</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John F. Love</i>				14. MOTHER'S MAIDEN NAME <i>Mittie</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mittie Love (mother)</i> Address <i>same as above</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>762.0 FETAL ATELECTASIS</i> DUE TO (b) <i>Possible Mongolism</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)						INTERVAL BETWEEN ONSET AND DEATH <i>1 hr. 25 mins.</i> <i>1 hr. 25 mins.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 24, 1957</i> , to <i>May 24, 1957</i> , that I last saw the deceased alive on <i>May 24, 1957</i> , and that death occurred at <i>8:30 A.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>R. Kennedy Skipton M.D.</i>							
PHYSICIAN'S NAME (Type) <i>7220 Forest Rd. Hyattsville, md</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>June 1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Prince George Southern Chesley Md</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Penn Jr. Edm</i> ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <i>JUN 10 '57</i>							

2077241XV3

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

CERTIFICATE OF DEATH

RECEIVED
JUN 10 1957
BUREAU V. B.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 245										
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale Md			c. LENGTH OF STAY IN 1b D O A		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville, Maryland.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital					d. STREET ADDRESS Baltimore avenue,.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Emily Middle Koontz Last Ludwig					4. DATE OF DEATH Month May 17, Day 19 57					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 30, 1909		9. AGE (In years last birthday) 47 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY own home			11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Milton S. Koontz					14. MOTHER'S MAIDEN NAME Ethel Duggonne					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Paul F. Ludwig same as number 2 (Husband) Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 3 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 353.3 Epilepsy								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation					22b. DATE THEREOF 5/18/57		22c. NAME OF CEMETERY OR CREMATORY Norfolk		22d. LOCATION (City, town, or county) (State) Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons					ADDRESS Hyattsville, Md		24a. REC'D BY REGISTRAR DATE 5/21/57		24b. REGISTRAR'S SIGNATURE James Lewis	

DATE SIGNED

May 17, 1957.

BUREAU V. 2

MAY 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05529

CERTIFICATE OF DEATH

Reg. Dist. No.

05495

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Suitland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1215--Swann Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BLANCHE Middle V. Last MAGILL		4. DATE OF DEATH Month May Day 5th Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 13th, 1877
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James H. Mahorney		14. MOTHER'S MAIDEN NAME Margaret T. Flaherty	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Catherine T. Purdy -215-Swann Rd, Suitland Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x Cerebral Thrombosis DUE TO (b) Anteriosclerosis, Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes mellitus (3 yrs) - Heart failure (2 yrs)		INTERVAL BETWEEN ONSET AND DEATH 10 days 3 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1954 to 5-5-1957, that I last saw the deceased alive on 5-4-1957, and that death occurred on 5-5-1957 at 3:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4223-Silver Hill Rd. SE May 5th, 1957			
ACTUAL SIGNATURE Dr. John P. D'Angelo		PHYSICIAN'S NAME (Type) 4223-Silver Hill Rd., SE	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-8-1957	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, DC	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros		24a. REC'D BY REGISTRAR DATE 7 1957	
24b. REGISTRAR'S SIGNATURE Carrie Campbell			

BUREAU V. S.

MAY 7 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

05530

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05496

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Morningside		c. LENGTH OF STAY IN 1b transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Morningside X2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Buffalo Sand and Gravel Pit				d. STREET ADDRESS 207 Pine Grove Dr.			
3. NAME OF DECEASED (Type or print) First Middle Last Eddie Marini				4. DATE OF DEATH Month Day Year May 28 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 19, 1947	
9. AGE (In years last birthday) 9 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student		10b. KIND OF BUSINESS OR INDUSTRY school		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Miresco Marini				14. MOTHER'S MAIDEN NAME Frances Fhreer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Miresco Marini, same as # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 9227.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Drowning DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) was swimming in pond and got in water over his head					
20c. TIME OF INJURY Hour X.XX p.m. 4:30 Month, Day, Year 5/28/57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Gravel Pit		20f. (City or town) (County) (State) Morningside, P.G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James I. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5-31-57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
23. FUNERAL DIRECTOR'S SIGNATURE James Pro.				ADDRESS 1661- Good Hope Rd SE Wash DC		24a. REC'D BY REGISTRAR DATE MAY 31 1957	
				24b. REGISTRAR'S SIGNATURE H. H. Sedwick		DATE SIGNED May 29, 1957	

MAY 31 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05491

CERTIFICATE OF DEATH

05497

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mt. Rainier, Md.	
c. LENGTH OF STAY IN 1b 3 Days		d. STREET ADDRESS 3334 Buchanan St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CORA Middle KALLAM Last MARTIN		DATE OF DEATH Month May Day 22nd Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26th, 1875
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR: Months 82 Days 22 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (State or foreign country) Rockingham Co., N.C.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Spencer Kallam	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT (Friend) Mr. Pearl Malew Address Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 Congested Heart failure due to general arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) to general arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 21st, 1957 to May 22nd, 1957 , that I last saw the deceased alive on May 22nd, 1957 , and that death occurred at 10:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6124 Central Ave DATE SIGNED Dr. Brainin			
ACTUAL SIGNATURE William Brainin M.D.		PHYSICIAN'S NAME (Type) Dr. Brainin	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/24/1957	
22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Roanoke, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W W Chambers		24a. REC'D BY REGISTRAR 5801 Cleveland	
24b. REGISTRAR'S SIGNATURE Overseer		25. DATE MAY 27 '57	

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
JAMES EARL RAY		MALE		35		WHITE		ATTORNEY	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
MEMPHIS, TENN.		5/4/68		5/6/68		10:00 AM		HEART DISEASE	
11. PLACE OF DEATH		12. DATE OF DEATH		13. TIME OF DEATH		14. CAUSE OF DEATH		15. MANNER OF DEATH	
MEMPHIS, TENN.		5/6/68		10:00 AM		HEART DISEASE		NATURAL	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESSES		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN	

BUREAU V. S.

MAY 27 1957

RECEIVED

05454

CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY Pr. George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Home				d. STREET ADDRESS 2701 Ct Ave.			
3. NAME OF DECEASED (Type or print) Ellen B First McLaughlin Middle Lost				4. DATE OF DEATH May 9th, 1957 Month Day Year 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH unknown	
9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Washington D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME John McLaughlin				14. MOTHER'S MAIDEN NAME Mary Purcell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Margaret Quaid -2701 Ct Ave N.W. D.C. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peripheral Vascular Disease 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral vascular accident DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.0 Arteriosclerosis heart disease				INTERVAL BETWEEN ONSET AND DEATH 4 to 10 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/5/50 , 19____, to 5/10/57 , 19____, that I last saw the deceased alive on 5/5/57 , 19____, and that death occurred at 3:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1841 Col Rd DATE SIGNED 5/10/57							
ACTUAL SIGNATURE E. H. Aschenbach M.D.				PHYSICIAN'S NAME (Type) E. H. Aschenbach, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-13-57		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE J Wm Lee's Sons Co. 300 4st N.E. D.C. ADDRESS				24a. REC'D BY REGISTRAR May 13 1957		24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severe	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

MAY 14 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
SM 9/55

05492

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05499

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				d. STREET ADDRESS 1 3904 Queensbury Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Eva Marie McLean				4. DATE OF DEATH Month Day Year May 28 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 12, 1895	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired clerk				10b. KIND OF BUSINESS OR INDUSTRY U.S. Treasury Dept.		11. BIRTHPLACE (State or foreign country) Kentucky	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Anthony Hellman				14. MOTHER'S MAIDEN NAME Cecelia			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Jean Maffucci, Bedford, Pa. Daughter	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				May 28, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/31/57		22c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		22d. LOCATION (City, town, or county) (State) Bedford Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR JUN 3 1957	
				24b. REGISTRAR'S SIGNATURE James E. Stevens			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Medical History		Present Illness		Previous Illnesses	
Physical Examination		Mental Examination		Autopsy	
Laboratory Examinations		Toxicology		Microbiology	
Radiology		Pathology		Histology	
Immunology		Genetics		Cytology	
Pharmacology		Nutrition		Endocrinology	
Oncology		Neurology		Pediatrics	
Geriatrics		Obstetrics		Gynecology	
Ophthalmology		Otolaryngology		Dermatology	
Cardiology		Pulmonology		Nephrology	
Hepatology		Gastroenterology		Urology	
Orthopedics		Neurosurgery		Plastic Surgery	
ENT		Oncology		Radiation Oncology	
Hematology		Immunology		Transfusion Medicine	
Allergy		Infectious Disease		Public Health	
Epidemiology		Biostatistics		Health Services Research	
Health Policy		Health Law		Health Economics	
Health Communication		Health Promotion		Health Equity	
Health Justice		Health Innovation		Health Leadership	
Health Management		Health Quality		Health Safety	
Health Security		Health Resilience		Health Sustainability	
Health Transformation		Health Future		Health Vision	

RECEIVED
JUN 3 1957
BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove casket papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14, See: Birth Cert. et

CERTIFICATE OF DEATH

05493

Reg. Dist. No.

05500

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmonston	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		d. STREET ADDRESS 5208 Decatur St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Baby Girl First McNab Middle Last		4. DATE OF DEATH 5-27-57 Month 5 Day 27 Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-27-57
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 1 Days 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Norman McNab		14. MOTHER'S MAIDEN NAME Nancy Theresa Limerick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no If yes, give war or dates of service		16. SOCIAL SECURITY NO.	
17. INFORMANT John W. Puckio		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Resp. failure secondary to bil. atelectasis 576X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) abscess left hemi-diaphragm DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/27 , 19 57 , to 5/27 , 19 57 , that I last saw the deceased alive on 5/27 , 19 57 , and that death occurred at 3:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Puckio		ADDRESS (Street, city or town, state) 5301 Hamilton St., Hyattsville, Md	
DATE SIGNED 5/28/57			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation June 1957		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Prince Georges Gen Hosp Cheverly MD		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Adrian		24a. REC'D BY REGISTRAR Adrian	
24b. REGISTRAR'S SIGNATURE Adrian		DATE JUN 10 '57	

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JUN 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05501

05494

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chaverly, Md.		c. LENGTH OF STAY IN 1b 1 Hr. 1/2 Hr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George General Hospital		e. STREET ADDRESS Croome Sta. Road	
3. NAME OF DECEASED (Type or print) First Grace Middle M. Last Moore		4. DATE OF DEATH Month May Day 3 Year 1957	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Smith		14. MOTHER'S MAIDEN NAME Matilda Diggs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT James M. Moore (Husband)		Address Same As Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic Heart Disease DUE TO (c) Diabetes Mellitus			INTERVAL BETWEEN ONSET AND DEATH hours years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.0			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1 May, 1957 to 3 May, 1957 that I last saw the deceased alive on 3 May, 1957 , and that death occurred at 7:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4814-71st Ave Landover Hills Md. DATE SIGNED 3-May-57 ACTUAL SIGNATURE Thomas G. Maloney M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-7-57	22c. NAME OF CEMETERY OR CREMATORY Mary's Church	22d. LOCATION (City, town, or county) (State) Croome, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Myrtle K. Rollins		24a. REC'D BY REGISTRAR W. S. C.	24b. REGISTRAR'S SIGNATURE DATE MAY 7 57

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED	
MAY 7 1957	
BUREAU V. S.	

MAY 7 1957

BUREAU A. B.

RECEIVED

05495

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY P. Gen.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ieland Memorial Hospital				d. STREET ADDRESS Box 545 Rt. 1			
3. NAME OF DECEASED (Type or print) Lawrence First Koontz Middle Moreland Last				4. DATE OF DEATH Month 5 Day 28 Year 57			
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-1-06		9. AGE (In years lost birthday) 50 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Fitter				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME George F. Moreland				14. MOTHER'S MAIDEN NAME Sally Clem			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 232 01 9183		17. INFORMANT Dessie Moreland Address Accokeek, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443 X DUE TO RT. hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive heart disease (c) 5 yrs						INTERVAL BETWEEN ONSET AND DEATH 3 yrs 3 yrs 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331 X						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 15, 1957 to May 28, 1957 , that I last saw the deceased alive on May 28, 1957 , and that death occurred at 8:45 M., from the causes and on the date stated above.							
ACTUAL SIGNATURE L W Malin M.D.				ADDRESS (Street, city or town, state) Riverdale Md DATE SIGNED 5-28-57			
PHYSICIAN'S NAME (Type) L W Malin M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-31-57		22c. NAME OF CEMETERY OR CREMATORY White Chapel ME Cem.		22d. LOCATION (City, town, or county) (State) Deitrick, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home ADDRESS Waldorf, Md.				24. REC'D BY REGISTRAR JUN 3 1957		24b. REGISTRAR'S SIGNATURE James Shoup	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

JUN 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05496

Items 11, 12, 13, 14 Film 6215 5-24-57 et

CERTIFICATE OF DEATH

05503

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 21 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Oliver Middle Morgan Last Morgan		4. DATE OF DEATH Month May Day 11 Year 19 57	
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Separated <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 Aug 1909
9. AGE (In years last birthday) yrs. 47		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Edgefield, S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Melligan Morgan		14. MOTHER'S MAIDEN NAME Hannah Morgan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 445X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Renal insufficiency - Nephroses Malignant Hypertension		INTERVAL BETWEEN ONSET AND DEATH 2 wks 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 May 1957 to 11 May 1957 , that I last saw the deceased alive on 10 May 1957 , and that death occurred at 2,30A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas J. Maloney		M.D. 4814-71st Ave. Catonsville, Md.	
PHYSICIAN'S NAME (Type)		DATE SIGNED 11 May 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-15-57	
22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		22d. LOCATION (City, town, or county) (State) Suitland Rd. SE	
23. FUNERAL DIRECTOR'S SIGNATURE Johnson & Jenkins		ADDRESS 4804 Isa Ave	
24a. REC'D BY REGISTRAR DATE MAY 15 57		24b. REGISTRAR'S SIGNATURE Alfred	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Date of Death		Time of Death		Cause of Death		Place of Death		Manner of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1912		Maryland		1957		10:00 AM		Heart Disease		Home		Natural		[Signature]		[Signature]	
Occupation		Marital Status		Education		Religion		Race		Color		Height		Weight		Temperature		Pulse		Respiration		Blood Pressure	
Teacher		Married		High School		Catholic		White		White		5'10"		170 lbs		98.6		72		20		120/80	
Date of Admission		Date of Discharge		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Necropsy		Date of Examination		Date of Postmortem		Date of Toxicology		Date of Microbiology	
1957		1957		1957		1957		1957		1957		1957		1957		1957		1957		1957		1957	

BUREAU V. 1

MAY 16 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05531

CERTIFICATE OF DEATH

05504

Reg. Dist. No. 237

1. PLACE OF DEATH o. COUNTY Prince Georges' MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges'			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights				c. LENGTH OF STAY IN 1b Life			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 District Heights							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7200 Gateway Blvd.				d. STREET ADDRESS 7200 Gateway Blvd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mary Middle Ann Last Mullikin		4. DATE OF DEATH Month May Day 19 Year 19 57.					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1876	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph W. Wells				14. MOTHER'S MAIDEN NAME Willie Ann Day			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT John Owen Mullikin-		Address 7200 Gateway Blvd., District Hghts, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Arteriosclerosis DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 3 days unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from May 17 , 19 57 , to May 19 , 19 57 , that I last saw the deceased alive on May 18 , 19 57 , and that death occurred at 3:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Paul C. VanNatta		M.D. 5440 Silver Hill Rd SE		DATE SIGNED 5/19/57			
PHYSICIAN'S NAME (Type) PAUL C VAN NATTA		ADDRESS (Street, city or town, state) Washington 28 DC					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/22/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros.				ADDRESS Upper Marlboro, Md.		24a. REC'D BY REGISTRAR DATE 5/31/57	
				24b. REGISTRAR'S SIGNATURE Cassie Campbell			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05505

Reg. Dist. No.

Y30

05450

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8318 Potomac Avenue			d. STREET ADDRESS 8318 Potomac Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Benjamin Middle Franklin Last Orndorff			4. DATE OF DEATH Month May Day 6 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 1, 1900		9. AGE (In years last birthday) 56 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Piano tuner		10b. KIND OF BUSINESS OR INDUSTRY Musical		11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Licurgus Orndorff			14. MOTHER'S MAIDEN NAME Gertrude Weiner		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-03-3609		17. INFORMANT Woodrow Orndorff; 2685 Eagle Street, Balt., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Barbiturate poisoning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Overdose DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Consumption of 100 sleeping pills with suicidal intent.			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 5-6- 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
		20f. (City or town) College Park, Pr. Geo. Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		May 6, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF May 8, 1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Masoleum	
				22d. LOCATION (City, town, or county) (State) Colmar Manor Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons			ADDRESS Hyattsville, Md.		
24a. RECEIVED BY REGISTRAR MAY 9 1957			24b. REGISTRAR'S SIGNATURE John Smith		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BARNHART, 10
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John J. Smith		May 1, 1967	
Age		35	
Sex		Male	
Race		White	
Usual Residence		Boston, Mass.	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Signature of Medical Examiner		Signature of Coroner	
[Signature]		[Signature]	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BARNHART, 10

BUREAU A. J.

MAY 9 1967

RECEIVED

05532

CERTIFICATE OF DEATH

05506

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Maryland c. LENGTH OF STAY IN 1b 1 day, 10 1/2 hr. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arden d. STREET ADDRESS 1152 5th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Parker				4. DATE OF DEATH Month Day Year May 26 1957			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-25-57	
9. AGE (In years lost birthday) yrs. 1		IF UNDER 1 YEAR Months Days Hours Min. 1 10 30		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James A. Bell				14. MOTHER'S MAIDEN NAME Helen Parker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. ---		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atelectasis (c) Pneumonia						INTERVAL BETWEEN ONSET AND DEATH 34 hrs 84 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/25 , 19 57 , to 5/26 , 19 57 , that I last saw the deceased alive on 5/26 , 19 57 , and that death occurred at 11:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE John W. Perkins				ADDRESS (Street, city or town, state) 5301 Hammett St. Hyattsville, Md.			
DATE SIGNED 5/27/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) 631-57		22b. DATE THEREOF 5-31-57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington & Sons				ADDRESS 467 N. St. N.W.			
24a. REC'D BY REGISTRAR DATE MAY 31 1957				24b. REGISTRAR'S SIGNATURE W. L. Smith			

2077171XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1882		BALTIMORE		BALTIMORE		MARYLAND	
MARRIAGE		DATE		PLACE		CITY		COUNTRY		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		1905		BALTIMORE		MARYLAND		MARYLAND		JANE HARRIS		MAY 1957		BALTIMORE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		SCHOOLING		SPECIAL INSTRUCTIONS		SIGNATURE OF DECEASED	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST		8		NONE		NONE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		NAME OF PHYSICIAN		DATE OF EXAMINATION		NAME OF REGISTRAR		DATE OF REGISTRATION	
MAY 1957		BALTIMORE		BALTIMORE		MARYLAND		DR. J. H. HARRIS		MAY 1957		J. H. HARRIS		MAY 1957	

BUREAU V. 8

MAY 31 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05533

05507

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X 2 Landover			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 6709 Landover Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Wallace Thomas Parker				4. DATE OF DEATH Month May Day 24 Year 1957			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH Sept. 29, 1900		9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Casterman		10b. KIND OF BUSINESS OR INDUSTRY Gov't Printing Office		11. BIRTHPLACE (State or foreign country) Virginia			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John W. Parker				14. MOTHER'S MAIDEN NAME Ardelia Byrd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Anna Dandridge, 1941 Lauretta Ave., Balt. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal disease 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John T. Maloney</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 24, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Shipping		22b. DATE THEREOF May 28, 1957		22c. NAME OF CEMETERY OR CREMATORY Trickland			
22d. LOCATION (City, town, or county) (State)							
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph Barber</i>		23a. ADDRESS 48 N. E. 1st St.		24a. REC'D BY REGISTRAR DATE MAY 28 '57			
24b. REGISTRAR'S SIGNATURE <i>W. J. ...</i>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John A. Taylor	
Sex		Male	
Race		Colored	
Date of Birth		Sept. 29, 1900	
Age		56	
Place of Birth		Virginia	
Usual Residence		1011 Lombard Ave., Baltimore, Md.	
Cause of Death		Cardiovascular renal disease	
Manner of Death		Natural	
Signature of Physician		John A. Taylor	
Signature of Medical Examiner		John A. Taylor	

BUREAU V. B.

MAY 28 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

05534

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05508

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 4904 Newton Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Francis Edward Proctor				4. DATE OF DEATH Month Day Year May 23, 1957					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-31-88			
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired engineer		11. BIRTHPLACE (State or foreign country) U.S. Bu. of Pr. & Eng. Dist. of Col.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Clagett Proctor		14. MOTHER'S MAIDEN NAME Maud Crown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. No.		17. INFORMANT Address Gertrude M. Proctor; same address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive cardiovascular disease. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 443X								INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 23, 1957					
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF May 25, 1957		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 27 '57			
						24b. REGISTRAR'S SIGNATURE Alfred			

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Time of death

6. Place of death

7. Name of physician

8. Name of hospital

9. Cause of death

10. Nature of injury

11. Name of coroner

12. Name of jury

13. Name of jury

14. Name of jury

15. Name of jury

16. Name of jury

17. Name of jury

18. Name of jury

19. Name of jury

20. Name of jury

21. Name of jury

22. Name of jury

23. Name of jury

24. Name of jury

25. Name of jury

26. Name of jury

BUREAU V. 5

1957 MAY 24

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05535

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05509

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Langley Park- Hyattsville			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hsopital				d. STREET ADDRESS 7929 15th Avenue			
3. NAME OF DECEASED (Type or print) First Steven Middle Paul Last Rice				4. DATE OF DEATH Month May Day 31 Year 1957			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 14, '57	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 78		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James A Rice				14. MOTHER'S MAIDEN NAME Reva Ann Whitmore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT James A. Rice, Same address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) 491X (c), stating the underlying cause lost. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED May 31, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/1/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR JUN 4 '57	
24b. REGISTRAR'S SIGNATURE W. H. Beach							

2076241XVI

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 16
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF CHURCH	
19. SIGNATURE OF MINISTERS		20. SIGNATURE OF OTHERS		21. SIGNATURE OF OTHERS	
22. SIGNATURE OF OTHERS		23. SIGNATURE OF OTHERS		24. SIGNATURE OF OTHERS	
25. SIGNATURE OF OTHERS		26. SIGNATURE OF OTHERS		27. SIGNATURE OF OTHERS	
28. SIGNATURE OF OTHERS		29. SIGNATURE OF OTHERS		30. SIGNATURE OF OTHERS	
31. SIGNATURE OF OTHERS		32. SIGNATURE OF OTHERS		33. SIGNATURE OF OTHERS	
34. SIGNATURE OF OTHERS		35. SIGNATURE OF OTHERS		36. SIGNATURE OF OTHERS	
37. SIGNATURE OF OTHERS		38. SIGNATURE OF OTHERS		39. SIGNATURE OF OTHERS	
40. SIGNATURE OF OTHERS		41. SIGNATURE OF OTHERS		42. SIGNATURE OF OTHERS	
43. SIGNATURE OF OTHERS		44. SIGNATURE OF OTHERS		45. SIGNATURE OF OTHERS	
46. SIGNATURE OF OTHERS		47. SIGNATURE OF OTHERS		48. SIGNATURE OF OTHERS	
49. SIGNATURE OF OTHERS		50. SIGNATURE OF OTHERS		51. SIGNATURE OF OTHERS	
52. SIGNATURE OF OTHERS		53. SIGNATURE OF OTHERS		54. SIGNATURE OF OTHERS	
55. SIGNATURE OF OTHERS		56. SIGNATURE OF OTHERS		57. SIGNATURE OF OTHERS	
58. SIGNATURE OF OTHERS		59. SIGNATURE OF OTHERS		60. SIGNATURE OF OTHERS	
61. SIGNATURE OF OTHERS		62. SIGNATURE OF OTHERS		63. SIGNATURE OF OTHERS	
64. SIGNATURE OF OTHERS		65. SIGNATURE OF OTHERS		66. SIGNATURE OF OTHERS	
67. SIGNATURE OF OTHERS		68. SIGNATURE OF OTHERS		69. SIGNATURE OF OTHERS	
70. SIGNATURE OF OTHERS		71. SIGNATURE OF OTHERS		72. SIGNATURE OF OTHERS	
73. SIGNATURE OF OTHERS		74. SIGNATURE OF OTHERS		75. SIGNATURE OF OTHERS	
76. SIGNATURE OF OTHERS		77. SIGNATURE OF OTHERS		78. SIGNATURE OF OTHERS	
79. SIGNATURE OF OTHERS		80. SIGNATURE OF OTHERS		81. SIGNATURE OF OTHERS	
82. SIGNATURE OF OTHERS		83. SIGNATURE OF OTHERS		84. SIGNATURE OF OTHERS	
85. SIGNATURE OF OTHERS		86. SIGNATURE OF OTHERS		87. SIGNATURE OF OTHERS	
88. SIGNATURE OF OTHERS		89. SIGNATURE OF OTHERS		90. SIGNATURE OF OTHERS	
91. SIGNATURE OF OTHERS		92. SIGNATURE OF OTHERS		93. SIGNATURE OF OTHERS	
94. SIGNATURE OF OTHERS		95. SIGNATURE OF OTHERS		96. SIGNATURE OF OTHERS	
97. SIGNATURE OF OTHERS		98. SIGNATURE OF OTHERS		99. SIGNATURE OF OTHERS	
100. SIGNATURE OF OTHERS		101. SIGNATURE OF OTHERS		102. SIGNATURE OF OTHERS	

RECEIVED
JUN 4 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05536

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05510

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 21 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		d. STREET ADDRESS Box 191	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alice Middle E. Last Ridgeway				4. DATE OF DEATH Month May Day 12 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH about May 17 1874?		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Forrestville Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Judson Richardson				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs Virginia M. Buck Address Upper Marlboro Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complete Bundle Branc Block DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascularrenal disease DUE TO (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 904.0 Fracture of left femur							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on floor of home					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 4 21 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Upper Marlboro P. G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				DATE SIGNED May 13, 1957			
EXAMINER'S NAME (Type) James I. Boyd				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-15-57		22c. NAME OF CEMETERY Epiphany Cem.		22d. LOCATION (City, town, or county) (State) Forrestville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Washington. H E				24a. REC'D BY REGISTRAR MAY 17 '57		24b. REGISTRAR'S SIGNATURE W.D. Leach	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. E.

MAY 17 1957

RECEIVED

05457

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> , MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lahome Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Xdefret Pleasant</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>310 Elm Avenue</u>				d. STREET ADDRESS <u>1500-68th Place</u>			
3. NAME OF DECEASED (Type or print) <u>EDWARD</u> First <u>F.</u> Middle <u>ROBERSON</u> Last				4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 5, 1888</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Post office</u>		11. BIRTHPLACE (State or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lee Roberson</u>				14. MOTHER'S MAIDEN NAME <u>not available</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Wm. D. Roberson</u> Address <u>310 Elm Ave 2nd fl</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>260x</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <u>Arterio-sclerotic C.V.R. Disease</u> (c) <u>Diabetes Mellitus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>5 years</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491x Bronchopneumonia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>May 4</u> , 1957, to <u>May 24</u> , 1957, that I last saw the deceased alive on <u>May 23</u> , 1957, and that death occurred at <u>6:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Brainin</u>				ADDRESS (Street, city or town, state) <u>6124 Central Ave</u>			
PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>				DATE SIGNED <u>5/24/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 27, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ADDISON CHAPEL</u>		22d. LOCATION (City, town, or county) (State) <u>Defret Pleasant Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. D. Roberson</u>				ADDRESS <u>254 CARROLL ST NW</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 27 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. D. Roberson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

[Faint, mostly illegible text from the reverse side of the document is visible through the paper. The text appears to be a medical or legal record, possibly a death certificate or a report of a disease, with various fields and headings that are difficult to decipher due to the bleed-through and fading.]

BUREAU V. 1

MAY 27 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
05497 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05512

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Dead on Arrival	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park	
f. STREET ADDRESS 9526 48th Place		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Benjamin Middle Robinson Last		4. DATE OF DEATH Month May Day 19 Year 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1891
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY University of Md.	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Bernard Robinson		14. MOTHER'S MAIDEN NAME Rosa Hershfield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 579-07-2530	
17. INFORMANT Hazel W. Robinson, Same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed chest, abdomen and pelvis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260 Diabetic			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Diver of an automobile that ran off the road and struck a tree	
20c. TIME OF INJURY Hour 5:30 P.M. Month, Day, Year 5/19/57 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route # 202		20f. (City or town) (County) (State) Upper Marlboro. G. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED May 19, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 5/22/57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem		22d. LOCATION (City, town, or county) (State) Ft. Myer, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington, D.C.		24a. REC'D BY REGISTRAR DATE MAY 22 '57	
24b. REGISTRAR'S SIGNATURE W. L. Leach			

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
John M. Robinson		35		Male		White	
Date of Death		Place of Death		Cause of Death		Manner of Death	
June 23, 1957		Home		Heart Disease		Natural	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Director	
[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
MAY 22 1957
BUREAU OF HEALTH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

05498

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05513
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 3508 Allison Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Clarence Henry Sartain, Sr.				4. DATE OF DEATH Month Day Year May 23, 1957			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 27, 1888	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired maintenance man		10b. KIND OF BUSINESS OR INDUSTRY Yeast		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Washington Sartain				14. MOTHER'S MAIDEN NAME Laura King			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Adelaide Teresa Sartain; same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 23, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 25, 1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 27 '57	
						24b. REGISTRAR'S SIGNATURE W. Beach	

MEDICAL CERTIFICATION

2

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased George Washington Carver		Sex Male	
Age 38		Race White	
Date of Death February 27, 1957		Place of Death Home	
Cause of Death Acute congestive heart failure		Manner of Death Natural	
Contributing Factors Cardiovascular renal disease		Occupation Farmer	
Residence Adelphi Terrace, Adelphi, Md.		Signature of Physician [Signature]	

BUREAU V. 81

MAY 22 1957

RECEIVED

05499

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05514

Reg. Dist. No.

239

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN 1b transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Railroad Station				d. STREET ADDRESS 4658 Kernwood Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Michael Last Schreyer				4. DATE OF DEATH Month May Day 1 Year 19 57			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1882		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY Race track		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Leonard Schreyer				14. MOTHER'S MAIDEN NAME Mary M. Eidman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Florence M. Schreyer Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				DATE SIGNED			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 1, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 4, 1957		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Thos. J. Tiekner & Sons = Baeto 17				24a. REC'D BY REGISTRAR DATE 5/2/57		24b. REGISTRAR'S SIGNATURE Willie Brachman	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
MAY 3 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05500

CERTIFICATE OF DEATH

05515
Reg. Dist. No. 234

1. PLACE OF DEATH o. COUNTY <i>Prince Georges, MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Capitol Heights</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Capitol Heights</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>302-61st Place</i>		d. STREET ADDRESS <i>1302-61st Place</i>	
3. NAME OF DECEASED (Type or print) First <i>LILLIE</i> Middle <i>P.</i> Last <i>SCOTT</i>		4. DATE OF DEATH Month <i>May</i> Day <i>22</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 1, 1871</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	9. AGE (In years—last birthday) <i>85</i> yrs. <input type="checkbox"/> UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <i>Columbus, Indiana</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Silas Ferguson</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT Address <i>Mrs Metzinger - 302-61st Place, Capitol Hgts</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0 Congestive Heart Failure</i> DUE TO (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i>10 years</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>434.1</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 15, 1954</i> , to <i>May 22, 1957</i> , that I last saw the deceased alive on <i>May 21, 1957</i> , and that death occurred at <i>11:30</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>6124 Central Ave</i> DATE SIGNED <i>5/22/57</i>			
ACTUAL SIGNATURE <i>William Brainin</i> M.D.		PHYSICIAN'S NAME (Type) <i>W.M. BRAININ</i> <i>Capitol Hgts Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5-25-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Suitland, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers Co. Washington, D.C.</i>		24b. REC'D BY REGISTRAR <i>5/24/57</i>	24c. REGISTRAR'S SIGNATURE <i>Carrie Campbell</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05516

05455

CERTIFICATE OF DEATH

Reg. Dist. No.

240

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 15			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 707 Chillum Rd. Apt. 201				d. STREET ADDRESS 707-Chillum Road apt 201			
3. NAME OF DECEASED (Type or print) Louise M Shropshire				4. DATE OF DEATH Month May Day 16 Year 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1869	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME unknown			
14. MOTHER'S MAIDEN NAME Margaret Arth				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Grace Shropshire-707 Chillum Road Address Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lf Ventricular failure, advanced arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a)) Similarity - Chronic Venous Insufficiency							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER).				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8/15/55 to 5/16/57 , 19, that I last saw the deceased alive on 5/15/57 , and that death occurred at 8 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Courtney				ADDRESS (Street, city or town, state) 3601-4th NW Washington			
PHYSICIAN'S NAME (Type) Dr. Courtney M.D.				DATE SIGNED 5/16/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/18/57		22c. NAME OF CEMETERY OR CREMATORY Prospect Hill		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company				24a. REC'D BY REGISTRAR DATE 5/17/57		24b. REGISTRAR'S SIGNATURE James Lender	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05501

CERTIFICATE OF DEATH

05517

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 35 Min. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 d. STREET ADDRESS Hyattsville, Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Herbert Staley Slinkman				4. DATE OF DEATH Month Day Year May 31 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-11-82	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired U S Gov't Accountant				10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md		11. BIRTHPLACE (State or foreign country) U S A	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Albert Slinkman				14. MOTHER'S MAIDEN NAME Lillie Staley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Herbert Payne Slinkman Hyattsville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH hrs.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 8 , 19 52 to 5/31 , 19 57 , that I last saw the deceased alive on 5/31 , 19 57 , and that death occurred at 6:05P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2409 Varian St DATE SIGNED 5/31/57 ACTUAL SIGNATURE Dr. Frederick E. Musser M.D. PHYSICIAN'S NAME (Type) Dr. Frederick Musser							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/4/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE JUN 4 '57		24b. REGISTRAR'S SIGNATURE Qu. Smith	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU V. 2

JUN 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
05502 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9 Film 6216 6-7-57 et
CERTIFICATE OF DEATH

05518

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u>	
c. LENGTH OF STAY IN b. <u>16 days</u>		d. STREET ADDRESS <u>115 Urell Place N.E.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>M.</u> Last <u>Spreading</u>		4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12 1868</u>
9. AGE (In years, last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Kalamazoo, Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Niles Winans</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Dillon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Justine Hoskins</u>		Address <u>2310 Ashmead Pl. Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of left hip - pathological?</u> DUE TO <u>157X</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <u>Carcinoma of head of pancreas</u> DUE TO <u>with metastases to liver & brain.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 17</u> , 19 <u>57</u> , to <u>May 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 17</u> , 19 <u>57</u> , and that death occurred at <u>9:05</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dayton O Watkins</u> M.D.		ADDRESS (Street, city or town, state) <u>5304 Annapolis Rd</u>	
PHYSICIAN'S NAME (Type) <u>DAYTON O WATKINS</u>		DATE SIGNED <u>6-17-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>5/20/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Kensico cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Valhalla, New York</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Company</u>		ADDRESS <u>Washington, D.C.</u>	
24a. REC'D BY REGISTRAR <u>MAY 20 57</u>		24b. REGISTRAR'S SIGNATURE <u>Albert Smith</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05503 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Prince Georges		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 Hour		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		13X2.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		e. STREET ADDRESS Reely's Trailer Ct. Rt 1 (See birth cert.)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Baby Girl		Middle Squires		Last		4. DATE OF DEATH Month May		Day 23	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 23-57		9. AGE (In years last birthday) 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Thomas Squires				14. MOTHER'S MAIDEN NAME Bessie Stanley					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mother -- as above		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Atelectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia (c) Interval between onset and death								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 5/23 , 19 57 , to 5/23 , 19 57 , that I last saw the deceased alive on 5/23 , 19 57 , and that death occurred at 6:45P M, from the causes and on the date stated above.									
ACTUAL SIGNATURE John W. Perkins		M.D.		ADDRESS (Street, city or town, state) 5301 Hamilton St, Hyattsville		DATE SIGNED 5/24/57			
PHYSICIAN'S NAME (Type) Dr. John Perkins									
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF June 1957		22c. NAME OF CEMETERY OR CREMATORY Prince Georges Cemetery		22d. LOCATION (City, town, or county) Cheverly Md		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Perkins		ADDRESS Adm.		24a. RECORDING REGISTRAR John W. Perkins		24b. REGISTRAR'S SIGNATURE John W. Perkins		DATE 5/24/57	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 100

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. CAUSE OF DEATH [Faint text]</p>		<p>8. MANNER OF DEATH [Faint text]</p>	
<p>9. DATE OF DEATH [Faint text]</p>		<p>10. TIME OF DEATH [Faint text]</p>	
<p>11. PLACE OF DEATH [Faint text]</p>		<p>12. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>13. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>14. SIGNATURE OF WITNESS [Faint text]</p>	

BUREAU V. S.

JUN 10 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

05537

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05520

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Prince George's</u>					
b. CITY OR TOWN (If outside corporate limits, write and give nearest town) <u>Allentown</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x1 Allentown</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7805 Steed Road SE</u>				d. STREET ADDRESS <u>7805- Allentown Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rabert</u> Middle <u>Edey</u> Last <u>Steed</u>				4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1957</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 29, 1865</u>			
9. AGE (In years last birthday) <u>91</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>			
13. FATHER'S NAME <u>John J R Steed</u>				14. MOTHER'S MAIDEN NAME <u>Mary Pamela Edelin</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>331X</u>		17. INFORMANT <u>Mary Steed, same as #2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra cranial hemorrhage</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u>								INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial May 26-57</u>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Steed private cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Allentown Md</u>				24a. REC'D BY REGISTRAR <u>May 27 1957</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel Burton</u>				24b. REGISTRAR'S SIGNATURE <u>E. H. Hedrick</u>					

MD 231
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME: *James I. Boyd*
 SEX: *Male*
 AGE: *45*
 DATE OF BIRTH: *May 1, 1912*
 PLACE OF BIRTH: *St. Louis, Mo.*
 OCCUPATION: *Police Officer*
 RESIDENCE: *1000 N. Broadway, Baltimore, Md.*
 DECEASED AT: *1000 N. Broadway, Baltimore, Md.*
 DATE OF DEATH: *May 27, 1957*
 TIME OF DEATH: *10:00 PM*
 CAUSE OF DEATH: *Myocardial Infarction*
 MANNER OF DEATH: *Natural*
 SIGNATURE OF EXAMINER: *James I. Boyd*
 TITLE: *Medical Examiner*
 COUNTY: *Baltimore*
 STATE: *Md.*

RECEIVED
 MAY 27 1957
 BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05521

Reg. Dist. No.

05538

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silesia</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silesia</u>			
c. LENGTH OF STAY IN 1b <u>46 years</u>				d. STREET ADDRESS <u>7960 Livingston Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7960 Livingston Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Waisy Myrtle Taylor</u>				4. DATE OF DEATH <u>May 2 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 6 1890</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>12</u>		IF UNDER 24 HRS. Hours <u>12</u> Min. <u>00</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>George Thorne</u>				14. MOTHER'S MAIDEN NAME <u>Julia Copen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>8000 Livingston</u>			
17. INFORMANT <u>Clyde Herbert Taylor Washington</u>				Address <u>8000 Livingston</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried May 4-57</u>				22b. DATE THEREOF <u>May 4-57</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Providence Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Frederick Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmors Bros</u>				24a. REC'D BY REGISTRAR <u>MAY 6 1957</u>			
				24b. REGISTRAR'S SIGNATURE <u>R. H. Hedrick</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
MAY 6 1957
BUREAU V. S.

05504

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY PRINCE GEORGE'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COTTAGE CITY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGE'S GENERAL HOSP.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LAVINA Middle THEIBAUT Last THEIBAUT				4. DATE OF DEATH Month MAY Day 1 Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-25-92	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Thomas D. Riley				14. MOTHER'S MAIDEN NAME Anna Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Albert K Theibault		Address Cottage City Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4 anemia DUE TO (c) Diabetes Mellitus						INTERVAL BETWEEN ONSET AND DEATH 4 days 6 mos 12 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 1 , 19 57 , to MAY 1 , 19 57 , that I last saw the deceased alive on MAY 1 , 19 57 , and that death occurred at 11/05AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Leon R. Levitsky M.D.				PHYSICIAN'S NAME (Type) LEON R. Levitsky			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 3, 1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR MAY 6 '57		24b. REGISTRAR'S SIGNATURE W. H. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

MAY 6 1957

RECEIVED

BUREAU V. S.

MAY 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05506

CERTIFICATE OF DEATH

05524

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges'	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro XO	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges' General Hospital		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Boy Middle Wedge. Last 4. DATE OF DEATH Month May Day 16, Year 19 57			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1957
9. AGE (In years lost birthday) yrs. 4 20		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Melvin Wedge		14. MOTHER'S MAIDEN NAME Agnes Diggs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. --	
17. INFORMANT Melvin Wedge		Address Upper Marlboro, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia 761.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Maternal Placenta Previa DUE TO (c) Unk.		INTERVAL BETWEEN ONSET AND DEATH 12 hrs 24 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 16 May , 19 57 , to 16 May , 19 57 , that I last saw the deceased alive on 16 May , 19 57 , and that death occurred at 9:25 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Upper Marlboro, Maryland DATE SIGNED 5/17/57 ACTUAL SIGNATURE R. B. Sasscer M.D. PHYSICIAN'S NAME (Type) R. B. Sasscer, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/18/57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros.		ADDRESS Upper Marlboro, Md.	
24a. REC'D BY REGISTRAR DATE MAY 20 1957		24b. REGISTRAR'S SIGNATURE W. B. Seach	

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MAY 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05456

CERTIFICATE OF DEATH

Reg. Dist. No.

05525

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md.				c. LENGTH OF STAY IN 1b x2 Hyattsville, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5505 40th Avenue..				d. STREET ADDRESS 5505 40th avenue..			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Mary Jane White				4. DATE OF DEATH Month May 23, Day 19 Year 57			
5. SEX white	6. COLOR OR RACE female	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 28, 1872	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own Home		11. BIRTHPLACE (State or foreign country) Indiana	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Patrick Comiskey				14. MOTHER'S MAIDEN NAME Mary Benson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Lillian M. White Address Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 722.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatoid arthritis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. p. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from APRIL 11 , 19 56 , to MAY 23 , 19 57 , that I last saw the deceased alive on MAY 23 , 19 57 , and that death occurred at 8:20 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4314 GALLATIN STREET DATE SIGNED _____ ACTUAL SIGNATURE C. R. D. M.D. M.D. _____ PHYSICIAN'S NAME (Type) AARON DEITZ, M.D. HYATTSVILLE, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/28/57		22c. NAME OF CEMETERY OR CREMATORY St Joseph Cemetery		22d. LOCATION (City, town, or county) (State) Evansville, Indiana	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24. REC'D BY REGISTRAR MAY 27 1957		24b. REGISTRAR'S SIGNATURE James [unclear]	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 28 1957	
AGE		SEX	
65		Male	
RACE		EDUCATION	
White		High School	
BIRTH DATE		BIRTH PLACE	
JAN 15 1892		BALTIMORE, MD	
OCCUPATION		CAUSE OF DEATH	
Retired		Heart Disease	
MANNER OF DEATH		PLACE OF DEATH	
Natural		Home	
CERTIFICATE NO.		FILE NO.	
100-100000		100-100000	

BUREAU V. 3

MAY 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14. See: Birth Cert. et

CERTIFICATE OF DEATH

05526

05507

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY c. LENGTH OF STAY IN lb 7 Hrs. 15 Min. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GEN. HOSP.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEANWOOD PARK d. STREET ADDRESS 7		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BABY Middle BOY Last WHITING		4. DATE OF DEATH Month MAY Day 26 Year 19 57			
5. SEX male	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1957	9. AGE (In years last birthday) yrs. 7	IF UNDER 1 YEAR Months 7 Days 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME Milton Louis Whiting, Sr.		14. MOTHER'S MAIDEN NAME Mildred Elizabeth Woodrow			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.0 Atelectasis DUE TO Hyaline Membrane Disease of Lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) From birth DUE TO (c) From birth					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from MAY 26 , 19 57 , to May 26 , 19 57 , that I last saw the deceased alive on May 26 , 19 57 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE John W. Piskin		ADDRESS (Street, city or town, state) 5301 Hamilton St., Hyattsville DATE SIGNED 5/27/57			
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
22d. LOCATION (City, town, or county) (State)					
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Piskin		ADDRESS Adm		24a. REC'D BY REGISTRAR Adm 24b. REGISTRAR'S SIGNATURE Adm	
DATE JUN 10 '57					

2077202XV2

RECEIVED

JUN 10 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

27

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18																								
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																								
05539																								
05527																								
Reg. Dist. No. 234																								
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) a. STATE Maryland b. COUNTY Prince Georges																			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Oaks					c. LENGTH OF STAY IN 1b 8 months					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Chapel Oaks														
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1105-57th Avenue					d. STREET ADDRESS 1105-57th Avenue					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) Anne Maria Wood					4. DATE OF DEATH May 19 1957																			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 7, 1872		9. AGE (In years last birthday) 85 yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. UNDER 24 HRS. Months Days Hours Min.												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY Own Home					11. BIRTHPLACE (State or foreign country) Washington D.C.					12. CITIZEN OF WHAT COUNTRY? U. S. A.									
13. FATHER'S NAME Thomas Bolden					14. MOTHER'S MAIDEN NAME Maria Clark																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No					16. SOCIAL SECURITY NO.					17. INFORMANT Mrs. L. Sullivan					Address same as #									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exhaustion 181x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of bladder DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial										22b. DATE THEREOF 5-21-57					22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery					22d. LOCATION (City, town, or county) (State) Washington, D. C.				
23. FUNERAL DIRECTOR'S SIGNATURE Robert G. McGuire										ADDRESS 1820 9th St. N.W. Washington, D.C.					24a. REC'D BY REGISTRAR DATE 5/22/57					24b. REGISTRAR'S SIGNATURE Carrie Campbell				
25. ACTUAL SIGNATURE James I. Boyd										M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 5-18-57				

DATE SIGNED

STATEMENT OF DEATH - JACOBSON 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1957

1. Name of Deceased		2. Date of Death		3. Place of Death	
4. Sex		5. Age		6. Race	
7. Occupation		8. Cause of Death		9. Manner of Death	
10. Signature of Medical Examiner		11. Signature of Coroner		12. Signature of Registrar	
13. Date of Report		14. Time of Report		15. Place of Report	
16. Name of Hospital		17. Name of Physician		18. Name of Nurse	
19. Name of Pathologist		20. Name of Anatomist		21. Name of Radiologist	
22. Name of Forensic Pathologist		23. Name of Toxicologist		24. Name of Microscopist	
25. Name of Chemist		26. Name of Biologist		27. Name of Botanist	
28. Name of Zoologist		29. Name of Geologist		30. Name of Astronomer	
31. Name of Meteorologist		32. Name of Oceanographer		33. Name of Geophysicist	
34. Name of Environmental Scientist		35. Name of Public Health Officer		36. Name of Health Officer	
37. Name of Sanitary Engineer		38. Name of Sanitary Inspector		39. Name of Sanitary Surveyor	
40. Name of Sanitary Engineer		41. Name of Sanitary Inspector		42. Name of Sanitary Surveyor	
43. Name of Sanitary Engineer		44. Name of Sanitary Inspector		45. Name of Sanitary Surveyor	
46. Name of Sanitary Engineer		47. Name of Sanitary Inspector		48. Name of Sanitary Surveyor	
49. Name of Sanitary Engineer		50. Name of Sanitary Inspector		51. Name of Sanitary Surveyor	
52. Name of Sanitary Engineer		53. Name of Sanitary Inspector		54. Name of Sanitary Surveyor	
55. Name of Sanitary Engineer		56. Name of Sanitary Inspector		57. Name of Sanitary Surveyor	
58. Name of Sanitary Engineer		59. Name of Sanitary Inspector		60. Name of Sanitary Surveyor	
61. Name of Sanitary Engineer		62. Name of Sanitary Inspector		63. Name of Sanitary Surveyor	
64. Name of Sanitary Engineer		65. Name of Sanitary Inspector		66. Name of Sanitary Surveyor	
67. Name of Sanitary Engineer		68. Name of Sanitary Inspector		69. Name of Sanitary Surveyor	
70. Name of Sanitary Engineer		71. Name of Sanitary Inspector		72. Name of Sanitary Surveyor	
73. Name of Sanitary Engineer		74. Name of Sanitary Inspector		75. Name of Sanitary Surveyor	
76. Name of Sanitary Engineer		77. Name of Sanitary Inspector		78. Name of Sanitary Surveyor	
79. Name of Sanitary Engineer		80. Name of Sanitary Inspector		81. Name of Sanitary Surveyor	
82. Name of Sanitary Engineer		83. Name of Sanitary Inspector		84. Name of Sanitary Surveyor	
85. Name of Sanitary Engineer		86. Name of Sanitary Inspector		87. Name of Sanitary Surveyor	
88. Name of Sanitary Engineer		89. Name of Sanitary Inspector		90. Name of Sanitary Surveyor	
91. Name of Sanitary Engineer		92. Name of Sanitary Inspector		93. Name of Sanitary Surveyor	
94. Name of Sanitary Engineer		95. Name of Sanitary Inspector		96. Name of Sanitary Surveyor	
97. Name of Sanitary Engineer		98. Name of Sanitary Inspector		99. Name of Sanitary Surveyor	
100. Name of Sanitary Engineer		101. Name of Sanitary Inspector		102. Name of Sanitary Surveyor	

BUREAU V. 3

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G215 5-20-57 et

CERTIFICATE OF DEATH

05540

Reg. Dist. No.

05528

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RT 2 - PEGMAR DRIVE				d. STREET ADDRESS RT 2 PEGMAR DRIVE			
3. NAME OF DECEASED (Type or print) JOHN MOSBY WOOSTER				4. DATE OF DEATH MAY 13 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUL 16, 1865	9. AGE (In years last birthday) 91 9/11	10. IF UNDER 1 YEAR Months 9 Days 11 Hours 11 Min. 11		11. IF UNDER 24 HRS. Months 9 Days 11 Hours 11 Min. 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREMAN		10b. KIND OF BUSINESS OR INDUSTRY D.C. GOVT.		11. BIRTHPLACE (State or foreign country) FAIRFAX VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Franklin Luther Wooster				14. MOTHER'S MAIDEN NAME Ruth Ellen Martin Wooster			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT (WIFE) MRS. MARTHA WOOSTER		Address RT 2 CLINTON	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, TERMINAL 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CONGESTIVE HEART FAILURE DUE TO (c) 16 HRS. 24 HRS.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 610X BENIGN PROSTATIC HYPERTROPHY						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NONE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE					
20c. TIME OF INJURY Month, Day, Year Hour a. m. NONE 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NONE		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT. 1955 , to MAY 13, 1957 , that I last saw the deceased alive on MAY 12, 1957 , and that death occurred at 4:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Arthur Shaver Jr. M.D. BRANCH AVE. CLINTON MD.				DATE SIGNED MAY 13 '57			
PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR.				ADDRESS (Street, city or town, state) BRANCH AVE. CLINTON MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-16-1957		22c. NAME OF CEMETERY OR CREMATORY FAIRFAX CEMETERY		22d. LOCATION (City, town, or county) (State) FAIRFAX VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hyson				ADDRESS 1300-N ST. N.W., D.C.		24a. REC'D BY REGISTRAR Carrie Campbell	
				DATE 5/14/57		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - JULY 18
CERTIFICATE OF DEATH

NAME OF DECEASED JOHN J. WOODWARD		AGE 45		SEX Male		RACE White		DATE OF DEATH July 18, 1957	
PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore		STATE Maryland		ZIP CODE 21201	
OCCUPATION None		EDUCATION None		MARRIAGE None		RELIGION None		CAUSE OF DEATH None	
MANNER OF DEATH None		CERTIFICATE OF DEATH None		CERTIFICATE OF DEATH None		CERTIFICATE OF DEATH None		CERTIFICATE OF DEATH None	

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Also known as MABEL WRIGHT:

film G216 6-20-57 L

CERTIFICATE OF DEATH

Reg. Dist. No. **05529**

1. PLACE OF DEATH a. COUNTY <u>Dr. Geo</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Dr. Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly, Md.</u>		c. LENGTH OF STAY IN 1b <u>17 dy</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Dr. Geo Open</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md.</u>	
3. NAME OF DECEASED (Type or print) <u>MABEL ANGLIA M. WRIGHT</u>		4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15, 1886</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
13. BIRTHPLACE (State or foreign country) <u>Pa.</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>Joseph Johnson</u>		16. MOTHER'S MAIDEN NAME <u>Mary Cook</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		18. SOCIAL SECURITY NO. <u> </u>	
19. INFORMANT <u>Mrs. Dorothy Gerhold</u>		20. ADDRESS <u>5108-42 Ave Hyattsville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ch. Glomerulonephritis & Chorea</u> <u>592X</u> DUE TO <u>Cerebral Arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>& left hemiplegia</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes Mellitus</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-7</u> , 19 <u>57</u> , to <u>5-25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5-25</u> , 19 <u>57</u> , and that death occurred at <u>9:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. L. Etienne</u> M.D.		DATE SIGNED <u>4/13/58</u>	
PHYSICIAN'S NAME (Type) <u>W. L. ETIENNE</u>		ADDRESS <u>College Park, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 28-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) <u>Suitland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Johnson</u>		24a. REC'D BY REGISTRAR <u> </u>	
ADDRESS <u>300-44 M.D.E. Ind. Co.</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>May 28 57</u>		 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05509

CERTIFICATE OF DEATH

Reg. Dist. No. 05530

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 12 hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park	
f. STREET ADDRESS 17 Walnut Lane		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Boy Zoski		4. DATE OF DEATH Month May Day 21 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 May 1957
9. AGE (In years lost birthday) yrs. 12		10. IF UNDER 1 YEAR Months Days Hours Min. 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Edward Zoski		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records Cheverly Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral anoxia (maternal hemorrhage) 760.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c) Placenta previa			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5/20 , 19 57 , to 5/21 , 19 57 , that I last saw the deceased alive on 5/21 , 19 57 , and that death occurred at 3:10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas A. Christensen M.D.		ADDRESS (Street, city or town, state) College Park DATE SIGNED 5/21/57	
PHYSICIAN'S NAME (Type) Thomas A. Christensen		College Park Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 22, 1957	22c. NAME OF CEMETERY OR CREMATORY Ammendale Cemetery	22d. LOCATION (City, town, or county) (State) Ammendale, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F Gasch's Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE MAY 24 '57	
		24b. REGISTRAR'S SIGNATURE Alfred Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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